Douglas A. Ducey
Governor

Craig C. Brown
Director

ARIZONA DEPARTMENT OF ADMINISTRATION

OFFICE OF THE DIRECTOR

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June 27, 2017

The Honorable Douglas A. Ducey, Governor, State of Arizona
The Honorable Steve Yarbrough, President, Arizona State Senate
The Honorable J.D. Mesnard, Speaker, House of Representatives
1700 West Washington Street
Phoenix, AZ 85007

Dear Governor Ducey, President Yarbrough, and Speaker Mesnard:

Pursuant to A.R.S. § 38-652 (G) and A.R.S. § 38-658 (B), we are pleased to present the *2016 Annual Report for the Health Insurance Trust Fund*, including a report on the performance standards for the health and dental plans.

Sincerely,

Craig C. Brown
Director

c: Richard Stavneak, Director, Joint Legislative Budget Committee
Geoffrey Paulsen, Staff, Joint Legislative Budget Committee
Rebecca Perrera, Staff, Joint Legislative Budget Committee
William Greeney, Acting Director, Office of Strategic Planning and Budgeting
Ashley Beason, Budget Analyst, Office of Strategic Planning and Budgeting
Derik Leavitt, Assistant Director, ADOA Budget and Resource Planning
Holly Henley, State Librarian and Director, Arizona Department of Library and Archives
Marie Isaacson, Director, ADOA Benefit Services Administration

ARIZONA **BENEFIT SERVICES** DIVISION

ARIZONA DEPARTMENT OF ADMINISTRATION

Annual Report 2016

Health Insurance Trust Fund

Doug Ducey
Governor

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Director

FOREWARD

The Arizona Department of Administration ("ADOA") offers health, dental, life, and disability insurance as well as medical and dependent care flexible spending accounts to the State of Arizona ("State") employees and Retirees. These combined group of benefits offered is referred to as Benefit Options. This report provides a broad overview of the Benefit Options program, and meets the requirements of the A.R.S. §38-652 (G) and A.R.S. §38-658 (B).

The data shown is presented for the period January 1, 2016 through December 31, 2016. The Active and Retiree plans were concurrent for this period.

Any questions relating to the contents of this report should be addressed to:

Arizona Department of Administration
Benefit Services Division
100 N. 15th Ave, Suite 260
Phoenix, AZ 85007

Telephone: 602-542-5008

Table of Contents and Figures

Table of Contents

Table of Figures

Report Background

This document reports the financial status of the Employee Health Insurance Trust Fund pursuant to A.R.S. §38-652 (G), which reads:

> The department of administration shall annually report the financial status of the trust account to officers and employees who have paid premiums under one of the insurance plans from which monies were received for deposit in the trust account since the inception of the health and accident coverage program or since submission of the last such report, whichever is later.

The Annual Report also reports the performance standards for the health plans pursuant to A.R.S. §38-658 (B), which reads:

> On or before October 1 of each year, the director of the department of administration shall report to the joint legislative budget committee on the performance standards of health plans, including indemnity health insurance, hospital and medical service plans, dental plans and health maintenance organizations.

Benefit Services Division accounts for the Benefit Options program in two different funds. The Special Employee Health Fund, also known as Fund 3015 of the Health Insurance Trust Fund ("HITF") encompasses the medical and dental programs and the appropriated expenditures for ADOA, Benefit Services Division operations. The ERE/Benefits Administration Fund, of Fund 3035, is primarily a "pass through" fund for other benefits including, vision, life, and disability insurance as well as flexible spending accounts.

The benefits offered are either self-insured or fully-insured. For year 2016, the medical and dental PPO plans were self-insured, whereas the dental HMO, vision, life and disability insurance plans were fully-insured.

The State's self-insured medical plan began on October 1, 2004. The State contracts with the medical and pharmacy vendors to provide network access and related discounts, claim adjudication and payment, and medical management including utilization management, case management and disease management. The State is responsible for the full cost of all claims and programs offered by the vendors.

The State's self-insured dental PPO began on January 1, 2013.

Schedules of premiums received and accounted for in Fund 3015, distributions by enrollments, incurred and paid medical/drug claims, and expenses related to the medical and dental plans are included within this Annual Report. Also included is a summary of premiums collected and paid for the life insurance, disability insurance, vision insurance, and flexible spending accounts for Fund 3035.
quick

All data provided herein is for Plan Year ("PY") 2016 running January 1, 2016 through December 31, 2016.

Please note statistics will vary from previous annual reports due to the late receipt of program data following the completion of the previous annual report. Further, the Benefit Services Division has moved to using a new data-mining platform called MedInsight to extract the data which further explains some of the variances in reported statistics. In no case does the variation represent a substantive change in trend.

Executive Summary

During PY 2016, ADOA offered a comprehensive insurance package through Benefit Options to approximately 134,000 members consisting of Active state and university employees, Retirees and their qualified dependents. The benefits offered in the package include medical, pharmaceutical, dental, flexible spending, vision, wellness, an employee assistance program (EAP), life and disability insurance.

For PY 2016 the sum of health and dental premiums collected was $804M with total plan expenses and transfers of $893.3M. Expenses include claims incurred in 2016 and prior plan years paid in PY 2016.

Health Plan

- The average annual plan expense, including claims, administrative costs and fees, per member was $6,255
    - Average Active member expense was $6,051; average Retiree member expense was $8,958
- The medical claims expense was $547.4M, excluding IBNR liability
    - The leading diagnosis category by cost remains to be the musculoskeletal system at 13% of total medical spend
    - Claims indicate that members are seeking appropriate level of care by seeking the majority of care from physicians or specialists
        - 4,059 physician visits per 1,000 members (slightly lower than prior years)
        - 209 urgent care visits per 1,000 members (slightly lower than prior years)
        - 215 emergency room visits per 1,000 members (slightly higher than prior years)
- The pharmacy claims expense was $181.8M
    - The leading therapeutic drug class by cost was diabetes at 12% of total pharmaceutical spend
    - Over 1.4M prescriptions were filled in PY 2016
        - Active employees filled an average of 9 prescriptions per year while Retirees filled an average of 29

Wellness Program

- Administered over 14,842 flu vaccines through 405 worksite or public events
- Administered over 7,871 screenings through 89 statewide worksite events resulting in 517 referrals to physicians for various health issues, which is a 34% increase in referrals over the prior year
- Paid out over $400k in incentive pay to 2,039 employees participating in the HIP program

Performance Measures

Financial guarantees are in place to manage the performance of the contracted vendors. Most vendors met the majority or all of the agreed-upon performance measures. However, estimated penalties of approximately $360K will be collected in PY 2017 from vendors failing to meet agreed upon PY 2016 performance targets in customer service, claims processing, appeals, reporting,

survey, and network management. During PY 2016, $385K of performance penalties were collected related to the PY 2015 performance period.

Health Insurance Trust Fund Review & Summary

PY 2016 expenses were covered by revenues collected and the unrestricted reserve.

Figure 1 is a cash statement of receipts received and expenses paid during PY 2016 that relate to PY 2016 as well as prior plan years.

ADOA Health Plan is the self- insured medical program and includes Aetna, Blue Cross Blue Shield ("BCBS") of Arizona, Cigna, and United Healthcare (UHC) networks. State and university Active employees and Retirees choose coverage from one of the self-insured networks. BCBS NAU is a fully-insured option available only to NAU Active employees and Retirees.

Effective January 1, 2014, all Medicare eligible participants covered under the State of Arizona Benefit Services Division health plans were transitioned from the Medicare Part D Drug Subsidy program to a Medicare Employer Group Prescription Drug Plan ("EGWP"). The EGWP program is a prescription drug plan that combines a standard Medicare Part D plan with additional

Special Employee Health Trust Fund Summary	
	Plan Year 2016
Beginning Fund Balance January 01, 2016^	**$369,000,031**
Revenues	
ADOA Benefit Options	$715,996,255
BCBS (NAU)	41,919,123
ADOA Dental Plan	42,138,298
PrePaid Dental Plan	3,671,871
Other Revenue	239,160
Total Revenues	**$803,964,707**
Expenditures	
Administrative Fees	$34,280,126
Medical Claims	592,607,960
Drug Claims	181,527,151
Dental Claims	37,154,528
Medicare Part D Retiree Drug Subsidy	(11,481,947)
BCBS (NAU) Premiums	40,427,829
Fully Insured Dental Premiums	3,599,246
Appropriated Expenses	4,968,834
Administrative/Cash Adjustments	30,306
Fund Transfers Out ^^	4,076,000
Federal Participation Reimbursement	6,158,416
Total Expenditures and Transfers	**$893,348,449**
Ending Fund Balance December 31, 2016	**$279,616,289**
Reserves	
IBNR Liability (Medical & Dental)	$98,663,139
Contigency Reserve (Medical & Dental)	98,663,139
Total Reserves	**$197,326,278**
Unrestricted Balance December 31,2016	**$82,290,011**

^ The ending balance from PY 2015 report equals to the beginning balance for PY 2016. PY 2015 ending balance was overstated by $53,565.

Figure 1: Health Insurance Trust Fund Summary

prescription drug coverage provided by the Benefit Services Division health plan. The EGWP program achieved savings of $11.5M in PY 2016.

Benefit Services Division holds reserves for paying claims that have been incurred but not reported ("IBNR") and for a contingency to cover any insufficiencies that may develop, such as actual medical trend exceeding assumed medical trend during rate setting, unplanned shifts in plan membership, unexpected catastrophic claims, and changes in provider reimbursement rates that may occur during each plan year.

Medical Plan Enrollment

Benefits Services Division offers medical coverage to the following employees and their dependents:

- Eligible state employees and university staff, officers, and elected officials
- State Retirees receiving pension benefits through any of the State retirement systems
- State employees or university staff accepted for long-term disability benefits
- State employees or university staff eligible for COBRA benefits

The three types of medical plans offered to eligible participants are the Exclusive Provider Organization (EPO), the Preferred Provider Organization (PPO) and the High Deductible Health Plan (HDHP) with Health Savings Account (HSA).

The EPO Plan
Within the EPO plan, services must be obtained from an in-network provider; out-of-network services are only covered in emergency situations. The employee pays the monthly premium and any required copay at the time of service. Employees who select the EPO plan may choose from four networks: Aetna, BCBS of Arizona, Cigna or UHC.

The PPO Plan
Within the PPO plan, services may be obtained from an in- or out-of-network provider. There is a separate in- and out-of-network deductible that must be met before copays or coinsurance (percent of the cost) are allowed. The employee pays the monthly premium and at the time of service pays 100% of the allowed amount of service until the deductible is met. After the deductible is met, the employee pays copays if the provider is in-network and co-insurance if the provider is out-of-network until the out of pocket maximum (OOP) is met. Once the OOP is met the plan pays 100% of services for the remaining plan year, with a few exceptions, e.g. pharmacy copays. Employees who select the PPO plan may choose from four networks: Aetna, BCBS of Arizona, Cigna or UHC. Employees at NAU also have the option of participating in their fully-insured BCBS NAU plan.

The HDHP with HSA Plan
Within the HDHP, services may be obtained from both in- and out-of-network providers. There is a separate in- and out-of-network deductible that must be met before coinsurance is allowed. The employee pays the monthly premium and at the time of service pays 100% of the allowed amount of service (except for qualified preventative services that are covered 100% by the plan) until the deductible is met. After the deductible is met, the employee pays co-insurance up to the out of pocket maximum at which time the plan pays 100% of any additional costs for the year.

Employees who enroll in the HDHP and are under the age of 65 are eligible to open an HSA. This account allows employees to make pre-tax contributions into the account and withdraw the monies to pay for healthcare related expenses. When the employee opens the HSA with the State HDHP, the State makes bi-weekly deposits to the account.
The HDHP is only available to Active employees and under the Aetna network.

The figure below shows how enrollment was distributed by plan and network between active, retired, university, and COBRA members. The subscriber references the employee and the member references the employee plus dependents.

Average Monthly Medical Enrollment by Plan & Network					
		2016		2015	
Network	Plan Type	Subscribers	Members	Subscribers	Members
Active	EPO	2,001	4,464	1,947	4,407
Retiree	EPO	252	329	247	318
University	EPO	2,170	4,189	2,161	4,109
COBRA	EPO	18	29	11	14
Active	PPO	240	454	158	253
Retiree	PPO	26	30	30	38
University	PPO	307	609	239	458
COBRA	PPO	3	5	1	1
Active	HDHP	502	1,063	409	830
Retiree	HDHP	0	0	0	0
University	HDHP	660	1,284	560	1,067
COBRA	HDHP	7	11	2	5
Total AETNA		**6,185**	**12,467**	**5,765**	**11,500**
Active	EPO	7,489	18,623	7,337	18,276
Retiree	EPO	1,197	1,635	1,149	1,549
University	EPO	3,317	7,014	2,967	6,243
COBRA	EPO	46	67	32	43
Active	PPO	863	1,907	545	1,108
Retiree	PPO	65	82	65	79
University	PPO	678	1,407	490	907
COBRA	PPO	12	21	3	4
Total Blue Cross Blue Shield AZ		**13,667**	**30,756**	**12,588**	**28,209**
Active	EPO	3,083	7,574	3,229	7,862
Retiree	EPO	595	776	588	767
University	EPO	1,364	2,959	1,368	2,957
COBRA	EPO	21	30	20	26
Total CIGNA		**5,062**	**11,339**	**5,205**	**11,612**
Active	EPO	18,541	45,156	19,704	47,698
Retiree	EPO	4,930	6,424	4,789	6,224
University	EPO	10,210	23,419	10,736	24,623
COBRA	EPO	88	138	81	115
Active	PPO	979	2,131	748	1,479
Retiree	PPO	94	114	97	119
University	PPO	849	1,846	789	1,637
COBRA	PPO	16	24	3	3
Total UnitedHealthcare		**35,707**	**79,252**	**36,947**	**81,898**
NAU only*	PPO	3,035	5,594	3,100	5,722
Total Blue Cross Blue Shield NAU		**3,035**	**5,594**	**3,100**	**5,722**
Total		**63,656**	**139,408**	**63,605**	**138,941**

Figure 2: Average Monthly Enrollment by Plan & Network

Medical Premiums

The tables below show the medical premium by plan and coverage tier per pay period for Active employees and Retirees. Retirees have two different tier structures: 1) those who are not enrolled in Medicare and have no dependents enrolled in Medicare and 2) those who either are enrolled in Medicare themselves or have a dependent who is enrolled in Medicare.

Active Medical Premiums per Pay Period (26 pay periods)*					
Plan	**Tier**	**Employee Premium**	**State Premium**	**Total Premium**	**State HSA Contribution**
EPO	Employee only	$18.46	$253.85	$272.31	-
	Employee + adult	$54.92	$521.54	$576.46	-
	Employee + child	$46.62	$338.77	$385.38	-
	Family	$102.00	$571.38	$673.38	-
PPO	Employee only	$47.08	$258.00	$305.08	-
	Employee + adult	$99.23	$545.54	$644.77	-
	Employee + child	$66.46	$365.08	$431.54	-
	Family	$115.85	$636.46	$752.31	-
HDHP	Employee only	$9.23	$171.69	$180.92	$27.69
	Employee + adult	$27.69	$355.85	$383.54	$55.38
	Employee + child	$23.54	$232.62	$256.15	$55.38
	Family	$51.23	$396.46	$447.69	$55.38

* University of Arizona has 24 pay period deductions

Figure 3: Active Employee Medical Premiums

Monthly Retiree Medical Premiums				
	Without Medicare		**With Medicare**	
Plan	**Tier**	**Premium**	**Tier**	**Premium**
EPO	Retiree only	$593	Retiree only	$442
	Retiree +1	$1,387	Retiree +1 (Both Medicare)	$878
			Retiree +1 (One Medicare)	$1,024
	Family	$1,869	Family (Two Medicare)	$1,166
PPO	Retiree only	$825	Retiree only	$789
	Retiree +1	$2,009	Retiree +1 (Both Medicare)	$1,576
			Retiree +1 (One Medicare)	$1,740
	Family	$2,197	Family (Two Medicare)	$1,980

Figure 4: Retiree Medical Premiums

Medical Premium vs. Plan Cost

The 2016 contribution strategy for the self-insured medical plan resulted in employees paying 12% of the average monthly premium while the state paid the remaining 88%. This ratio remains unchanged from PY 2015. The overall premium revenue collected was not sufficient to cover expenses in PY 2016 and the fund was not structurally balanced. However, the fund had sufficient carry-over balance from prior years to cover all expenses in the fund in PY 2016.

The figure below shows how the average monthly premium compared to the average monthly plan cost for Active employees and Retirees and their dependents (Active and Retiree members). Pursuant to A.R.S. §38.651.01 (B), Retiree and Active medical expenses shall be grouped together to "obtain health and accident coverage at favorable rates." This requirement results in lower Retiree premiums and higher active premiums than what their experiences would otherwise dictate.

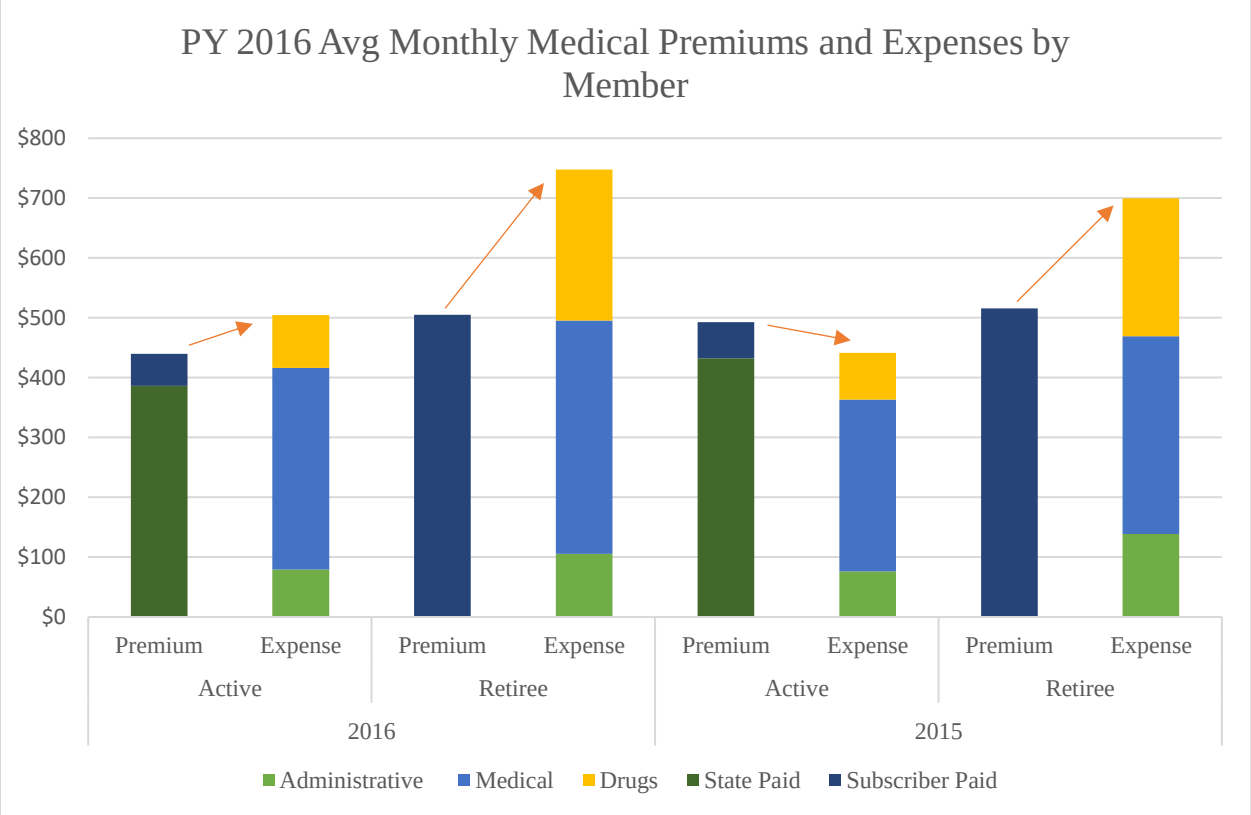


Figure 5: Average Monthly Medical Premium vs Expense

Expenses for Self-Insured Medical Plans

The figures below show the distribution of claims and expenses incurred in PY 2016 and the average annual cost to insure each type of subscriber/member.

2016 Incurred and Paid Self-funded Medical Expenses by Active, Retiree, and Plan						
Expenses	**Overall**	**Active**	**Retiree**	**EPO**	**PPO**	**HDHP**
Medical Claims	$547,440,001	$503,423,754	$44,016,247	$503,886,978	$39,503,952	$4,049,071
Drug Claims	$181,800,403	$139,544,275	$42,256,127	$164,944,282	$15,963,783	$892,337
Medicare Part D Subsidy	($11,481,947)	$0	($11,481,947)	($10,468,751)	($1,013,196)	$0
Rebates & Recoveries	($11,054,801)	($8,485,318)	($2,569,483)	($10,029,825)	($970,715)	($54,261)
Administration Fees	$32,550,574	$28,684,794	$3,865,781	$29,787,045	$2,222,732	$540,798
Appropriated Expenses	$4,737,194	$4,176,090	$561,103	$4,323,477	$322,621	$91,096
Total Expenses	$743,991,423	$667,343,595	$76,647,828	$682,443,205	$56,029,177	$5,519,041
IBNR Liability	$93,005,139	$85,527,174	$7,477,965	$85,605,872	$6,711,367	$687,901
Total	$836,996,562	$752,870,769	$84,125,793	$768,049,077	$62,740,543	$6,206,942
Enrollment in self-funded plans						
Subscribers	60,431	53,273	7,158	55,153	4,116	1,162
Members	133,813	124,421	9,392	122,769	8,684	2,360
Annual cost						
Per subscriber	$13,850	$14,132	$11,753	$13,926	$15,245	$5,341
Per member	$6,255	$6,051	$8,958	$6,256	$7,225	$2,631

Figure 6: Self-Insured Expenses by Active, Retiree, and Plan

2016 Incurred and Paid Self-funded Medical Expenses by Plan for Active & Retiree						
		Active	**Active**	**Active**	**Retiree**	**Retiree**
Expenses (in dollars)	**Overall**	**EPO**	**PPO**	**HDHP**	**EPO**	**PPO**
Medical Claims	$547,440,001	$460,975,139	$38,399,544	$4,049,071	$42,911,839	$1,104,408
Drug Claims	$181,800,403	$123,800,490	$14,851,448	$892,337	$41,143,792	$1,112,336
Medicare Part D Subsidy	($11,481,947)	$0	$0	$0	($10,468,751)	($1,013,196)
Rebates & Recoveries	($11,054,801)	($7,527,980)	($903,077)	($54,261)	($2,501,845)	($67,638)
Administration Fees	$32,550,574	$26,020,683	$2,123,313	$540,798	$3,766,362	$99,419
Appropriated Expenses	$4,737,194	$3,776,804	$308,191	$91,096	$546,673	$14,430
Total Expenses	$743,991,423	$607,045,135	$54,779,418	$5,519,041	$75,398,070	$1,249,759
IBNR Liability	$93,005,139	$78,315,536	$6,523,738	$687,901	$7,290,336	$187,629
Total	$836,996,562	$685,360,671	$61,303,156	$6,206,942	$82,688,406	$1,437,387
Enrollment in self-funded plans						
Subscribers	60,431	48,180	3,932	1,162	6,974	184
Members	133,813	113,602	8,460	2,360	9,167	224
Annual cost						
Per subscriber	$13,850	$14,225	$15,593	$5,341	$11,857	$7,808
Per member	$6,255	$6,033	$7,246	$2,631	$9,020	$6,407

Figure 7: Self-Insured Expenses by Plan for Actives and Retirees

Medical Expenses Associated with Medical Diagnoses

The tables below show the trend in cost by diagnosis for Actives and Retirees. For Actives, the first five categories make up approximately 45.0% ($264.2M) of the total PY 2016 medical spend. Further, the top five medical categories for Actives have decreased by 2.7% ($7M) since PY 2015.

Circulatory diagnosis group has experienced the largest percentage growth for the Active population in PY 2016 over PY 2015 with 14.1% increase while the Neoplasms treatment group has experienced the largest drop from PY 2015 to PY 2016 of 9.6% in the top ten categories.

For Retirees, spending on the top five categories has increased in PY 2016 over PY 2015 by 11.84% ($2.7M). Thus, the increase in Retiree spend is increasing the amount that the Active employees subsidize the Retiree premiums. The top five categories make up approximately 48.6% ($25.1M) of the total PY 2016 Retiree medical spend. Musculoskeletal System/Connective Tissue treatment group continues as the largest spend category for both the Active and Retiree populations. The highest percentage growth for the Retiree population can be seen in the Nervous System and Sensory Organs diagnosis group with a 70.4% increase in expenditures in PY 2016 over PY 2015.

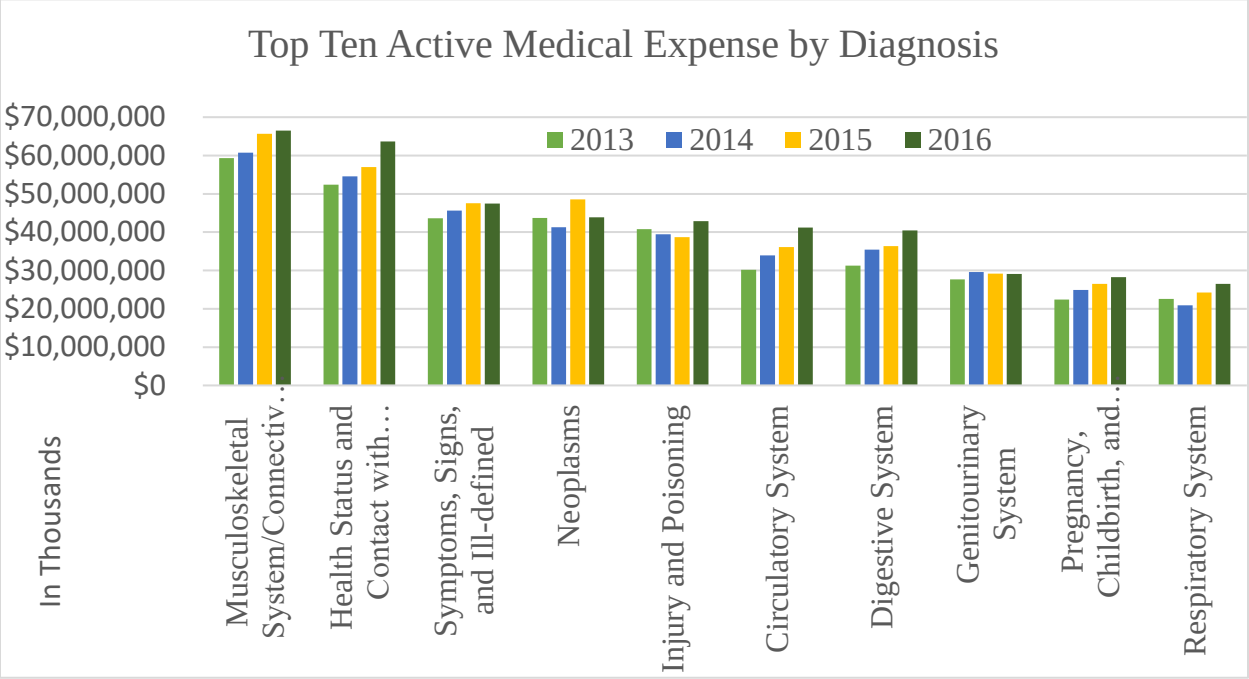


Figure 8: Top Ten Active Medical Expense by Diagnosis

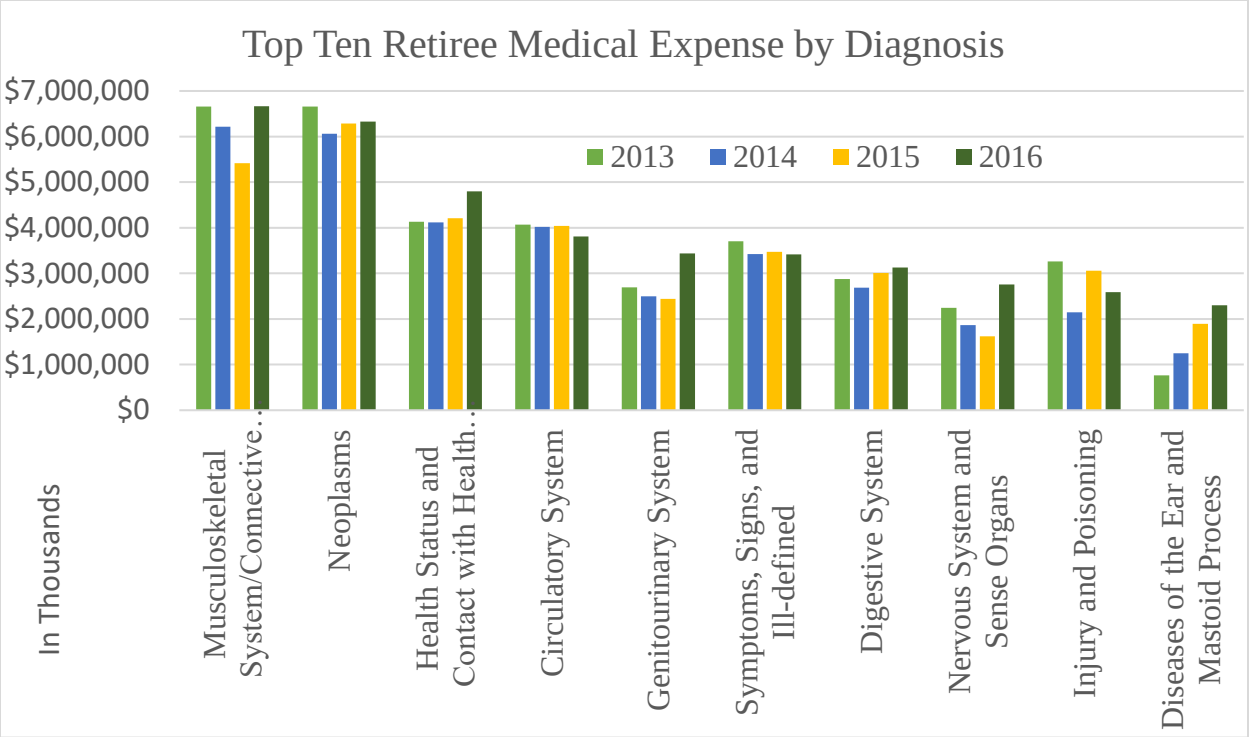


Figure 9: Top Ten Retiree Medical Expense by Diagnosis

Hospital Care

Inpatient hospital care represents a significant portion of total medical expenses. The tables below show the Hospital Admissions per 1,000 members and average length of stay. Retirees are admitted more often and longer than active employees which is in line with their higher overall costs. When comparing plans, PPO members are admitted more often than EPO members which are admitted more often than HDHP members. This is all in line with the average costs of these members in each plan. The length of stay is similar between the EPO and PPO, however, the active employees in the HDHP tend to have a shorter length of stay.

The number of hospital admissions is holding steady; however, the length of stay has seen a slight increase.

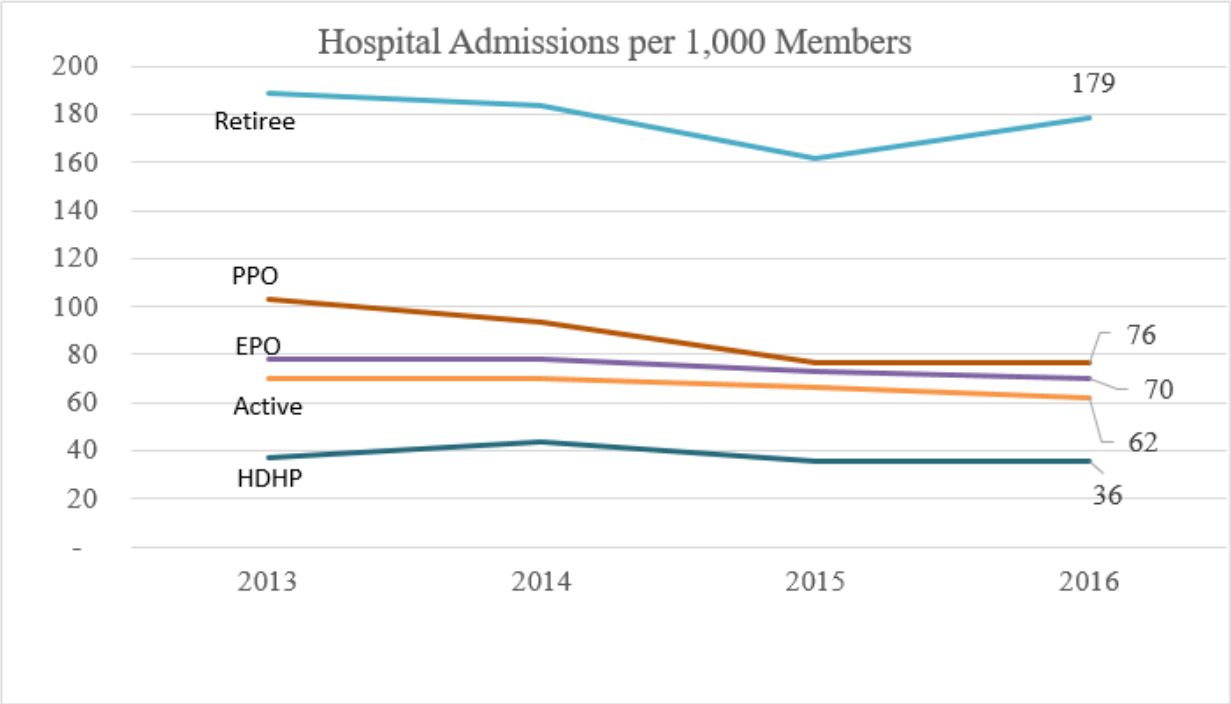


Figure 10: Hospital Admissions per 1,000 Members

The tables below represent the PY 2016 cost share of the inpatient stays.

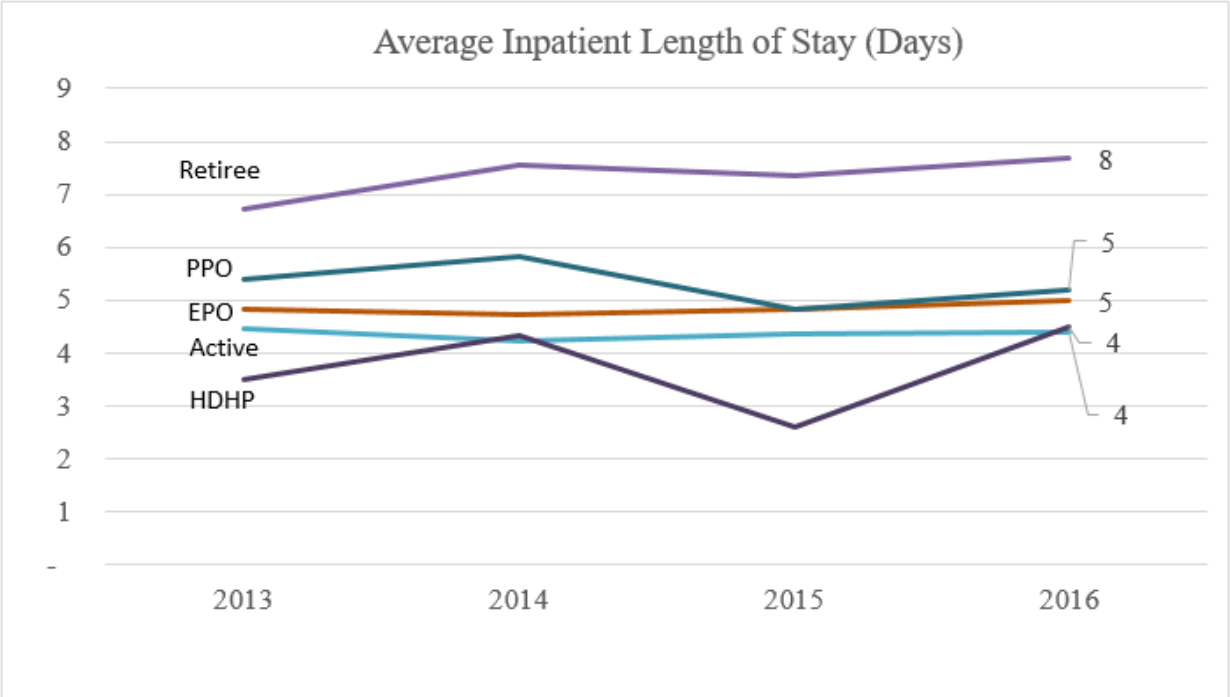


Figure 11: Average Inpatient Length of Stay

There is greater cost sharing with the Retirees because approximately two-thirds of Retirees have Medicare paying as primary for their claims. Overall, the Plan paid approximately 98% ($136.9M of $139.6M total) of Active in-patient costs and 15% ($10.1M of $66.2M total) of Retiree in-patient costs during 2016. This cost sharing experience has been about the same over the last four years. The chart below indicates that retirees cost slightly less than actives, however, the cost per admission does include the cost of skilled nursing facilities. Retirees more often than not require additional medical care following hospital admission and therefore cost more on a per member per month basis. Retirees' greater utilization of skilled nursing facilities drives down the average cost per hospital admission. However, on a per member per month basis, allowed hospital costs for retirees are substantially higher than for actives.

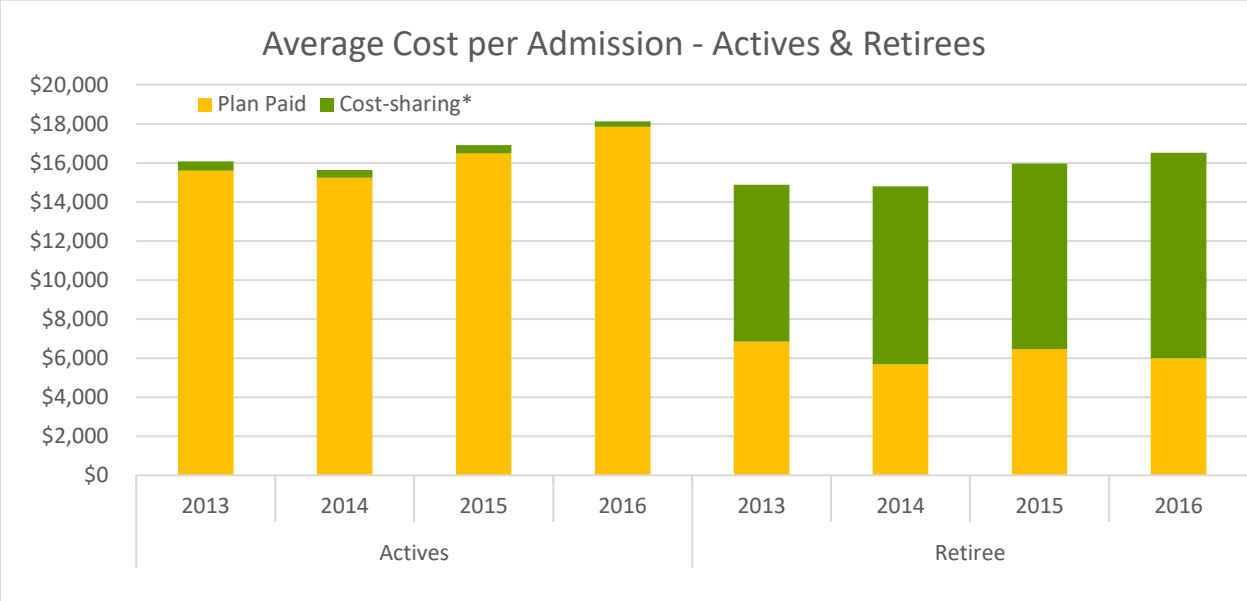


Figure 12: Average Cost per Admission - Active & Retiree

* Includes copay, co-insurance, Medicare, and other insurance

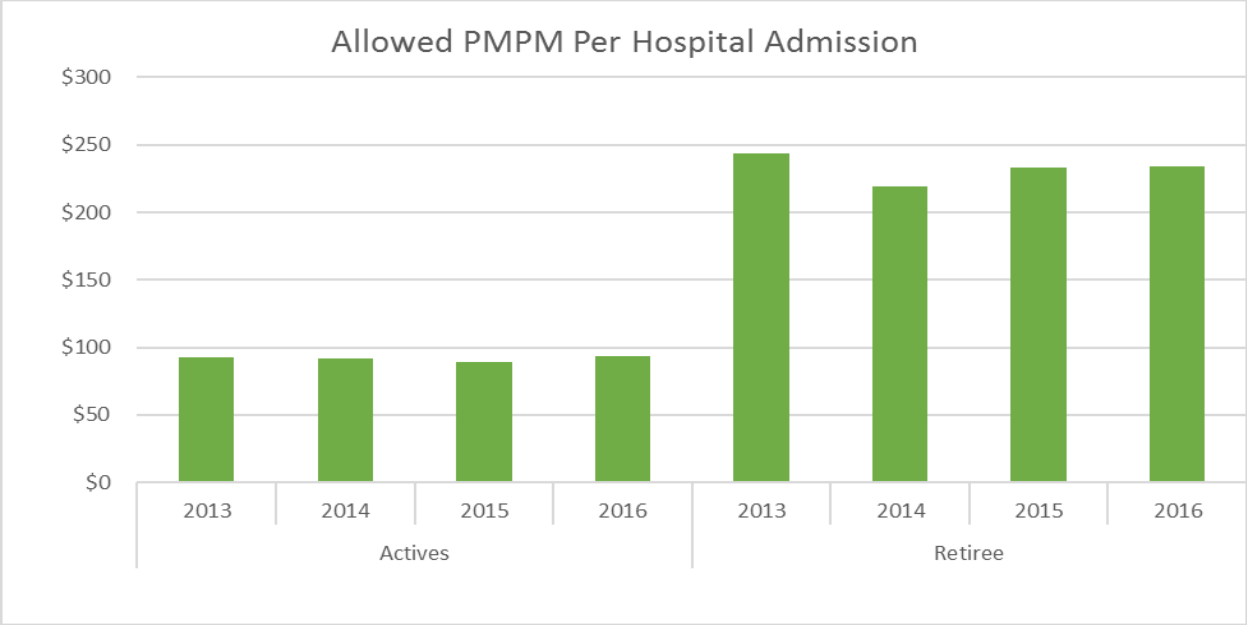


Figure 13: Allowed PMPM Per Hospital Admission - Active & Retiree

* Includes copay, co-insurance, Medicare, and other insurance

When looking at the cost by plan, there is greater cost share for the EPO and PPO than the HDHP due to Retirees in the EPO and PPO plans utilizing Medicare as the primary payer and not eligible for the HDHP. Overall, the Plan paid approximately 87% ($135.3M of $155.1M total) of EPO, 87% ($10.5M of $12.0M total) of PPO and 95% ($1.2M of $1.3M total) of HDHP inpatient costs during PY 2016 which is consistent with the prior three years network claims.

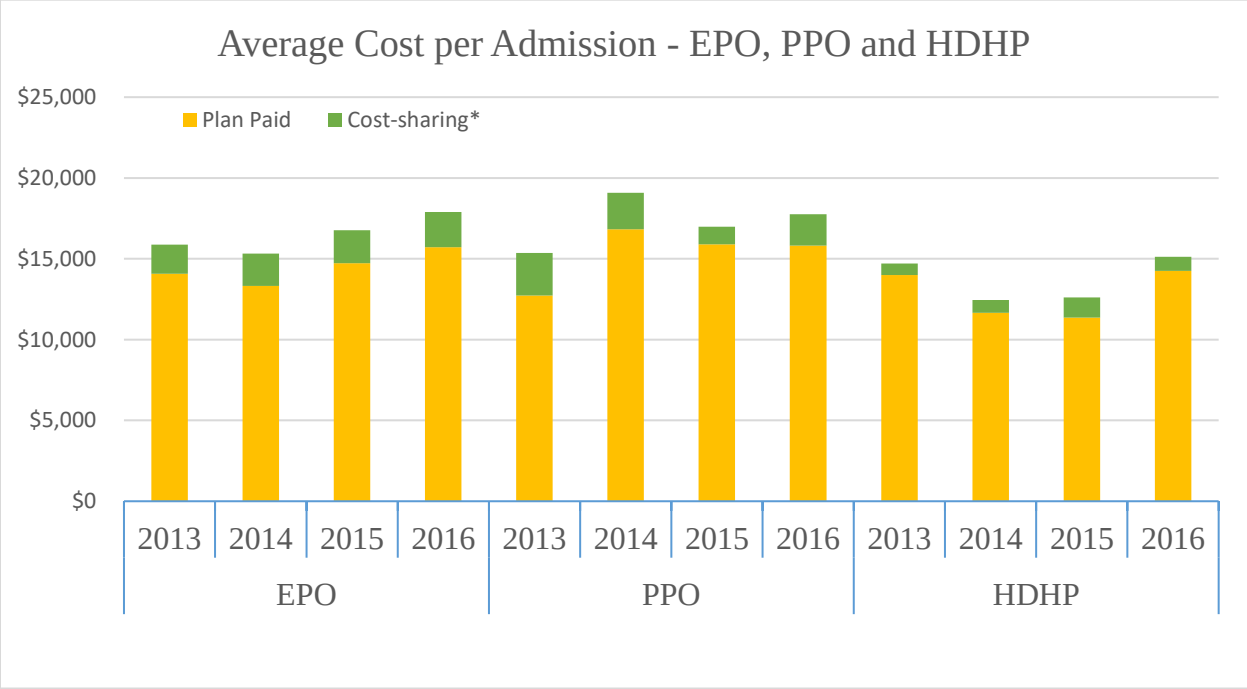


Figure 14: Average Cost per Admission - EPO, PPO, & HDHP

* Includes copay, co-insurance, Medicare, and other insurance

Place of Service

The figures below show the total cost by place of care for Active and Retirees over the past three years. Increasing medical costs consistent with the industry trend as well as a slight increase in both Active and Retiree membership are the main causes of the increase in costs for most service settings.

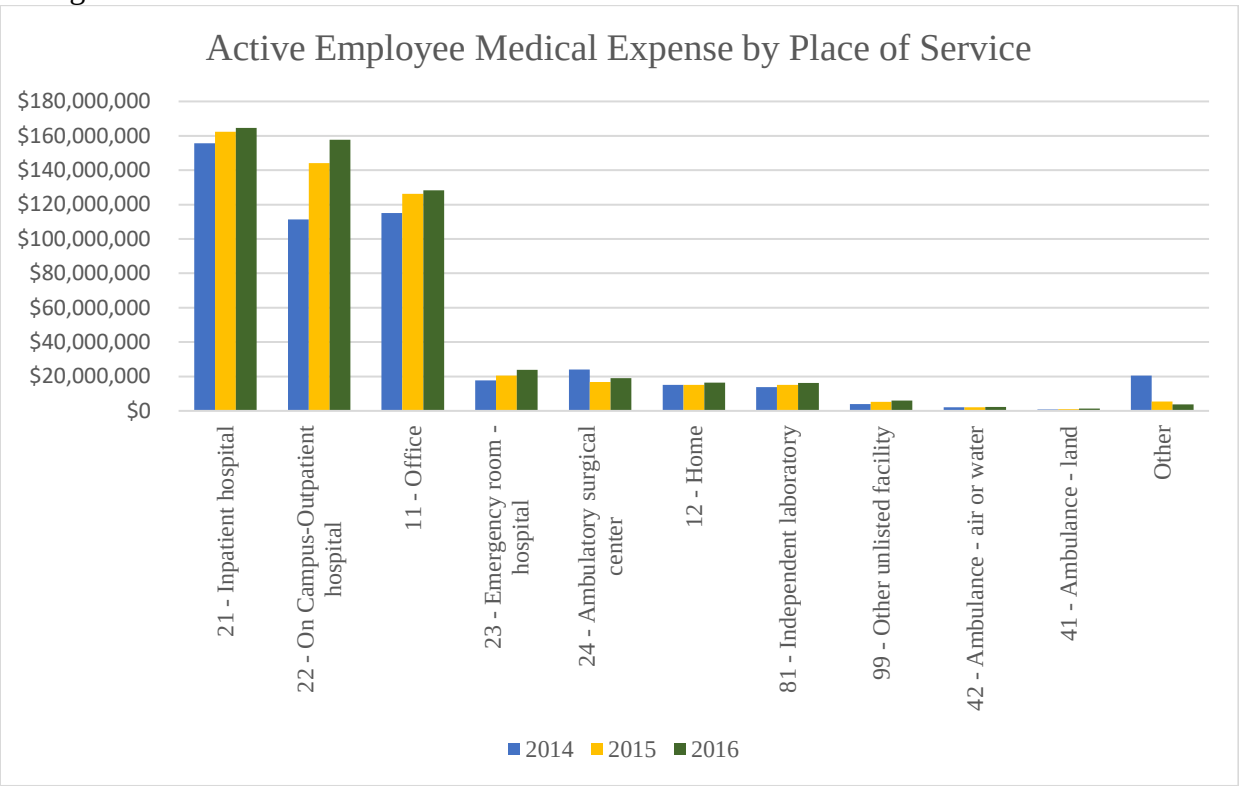


Figure 15: Medical Expense by Place of Service – Actives

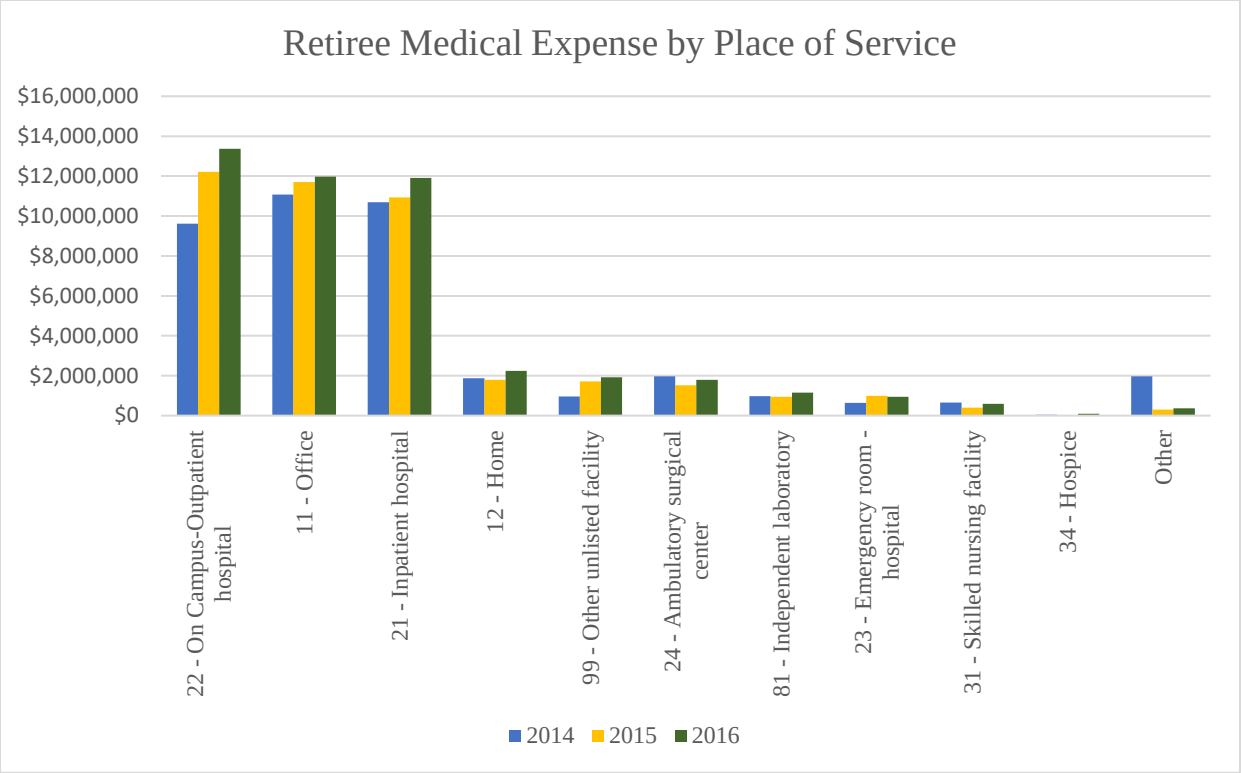


Figure 16: Medical Expense by Place of Service - Retirees

Emergency

During PY 2016 there were approximately 215 emergency room visits per 1,000 members of the self-funded plan. The average plan cost per visit was $1,224 (inclusive of both facility and professional costs). This is consistent with the prior two years ranging between 217 and 219 in utilization and between $1,147 and $1,161 in costs.

Urgent Care Visits

During PY 2016 there were approximately 209 urgent care visits per 1,000 members of the self-funded plan. The average plan costs per urgent care visit was $117. Utilization has increased from 181 in 2014 to 203 in 2015 and then to 209 in 2016. Costs have increased from $112 in PY 2014 to $117 in PY 2017.

Physician Visits

During PY 2016 there were approximately 4,059 physician visits per 1,000 members of the self-funded plan (or each member of the plan visited a physician's office approximately four times on average). The average plan costs per office visit in PY 2016 was $99. Utilization is slightly higher than the prior two years ranging from 3,952 in PY 2014 to 3,956 in PY 2015. Costs have increased over the last three years from $94 in PY 2014, to $95 in PY 2015 and to $99 in PY 2016.

Annual Prescription Use

The table below show the average number of prescriptions filled by Active and Retiree members, including those that did not utilize the pharmacy benefit at all during the year. This shows a slight positive downward trend for the retiree population; meaning as new people are coming on the plan, they are utilizing the pharmacy benefit at a lower rate than those already on the plan. The Active population's utilization has been steady between PY 2014 and PY 2016 at an average of 9.4 filled prescriptions per year.

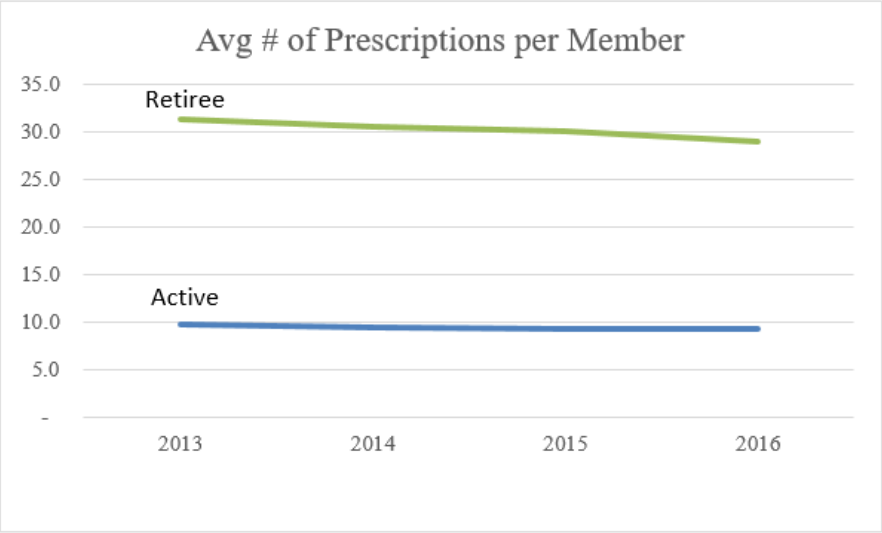
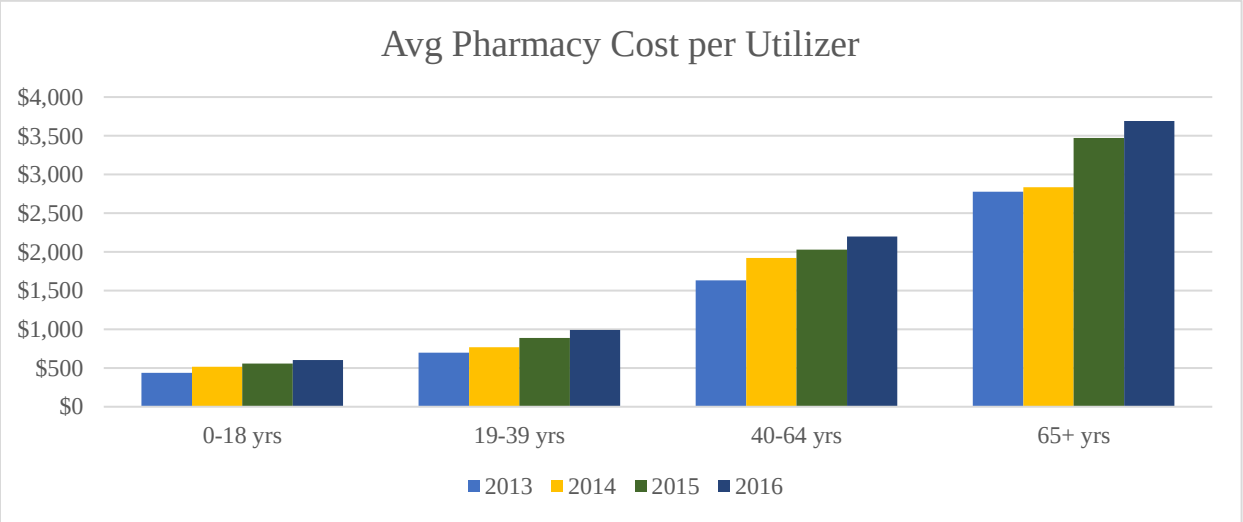


Figure 17: Average # of Prescriptions by Member

When examining the utilization of the pharmacy benefit, it shows those utilizing the pharmacy benefit are overall maintaining or even decreasing the number of prescriptions filled but the cost per utilizing member is steadily increasing. This indicates an increasing overall cost in the pharmacy benefit.



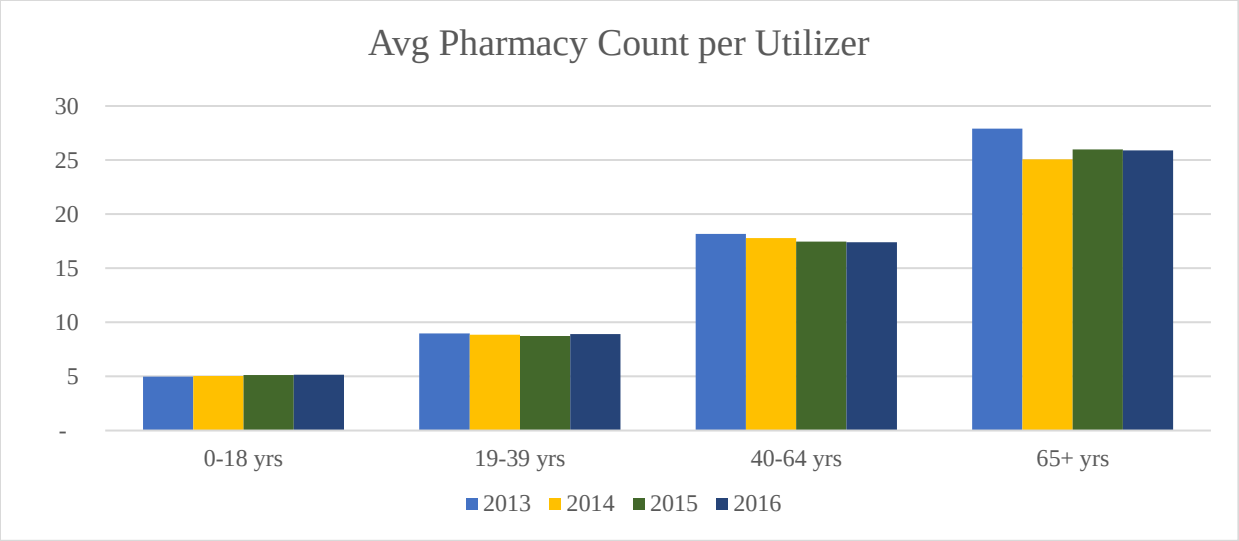


Figure 18: Pharmacy Cost and Count by Utilizer

Generic and Brand-Name Prescription Utilization

The table below shows a positive trend in the utilization of the lower cost drugs. Generic drugs tend to have the lower overall cost to the plan, preferred have a higher cost to the plan and non-preferred tend to have the highest cost to the plan. The trend shown below indicates a slight increase in the utilization of the generic drugs with a slight decrease in preferred and non-preferred drugs and that generic drugs make up an increasing count of total drugs (just under 83% in PY 2016).

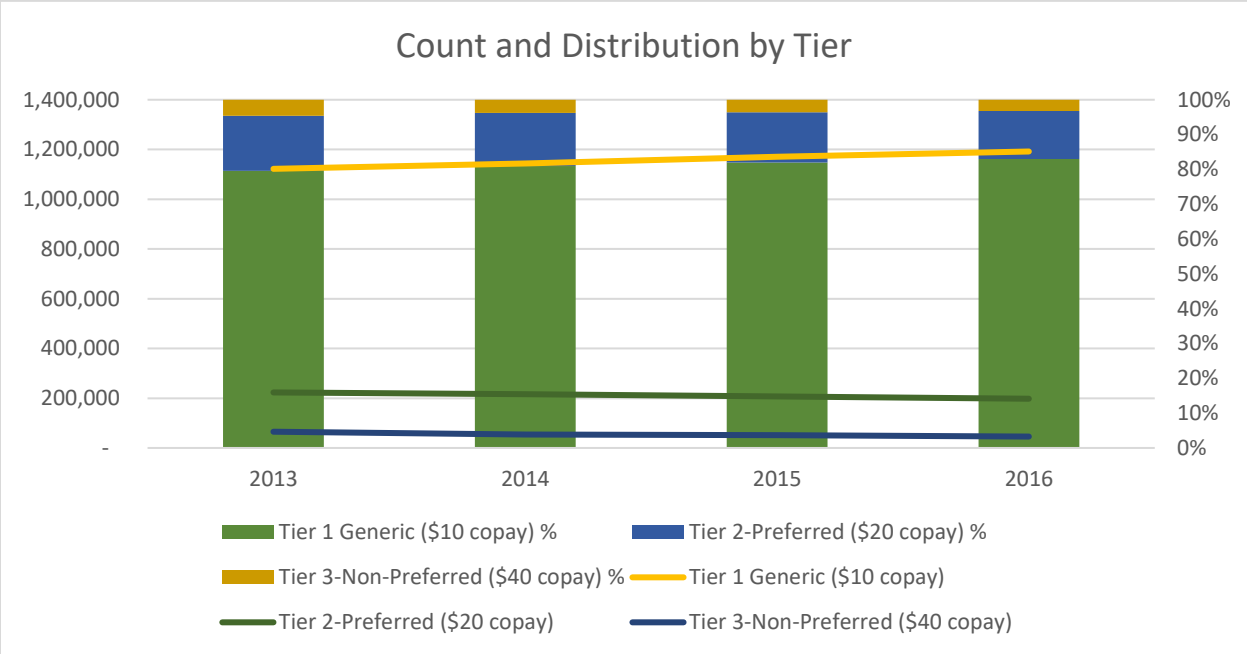


Figure 19: Pharmacy Count and Distribution by Tier

Prescription Use by Therapeutic Class

The graph below shows spend by therapeutic class by year. In over half of top ten classes, expenses have increased which is driving the overall increase in pharmaceutical spend. The top ten classes make up approximately 53.3% ($96.9M) of the total spend ($181.8M) in PY 2016 which is slightly up from 51.8% in PY 2015. Diabetes and inflammatory disease appear to be the highest cost drivers.

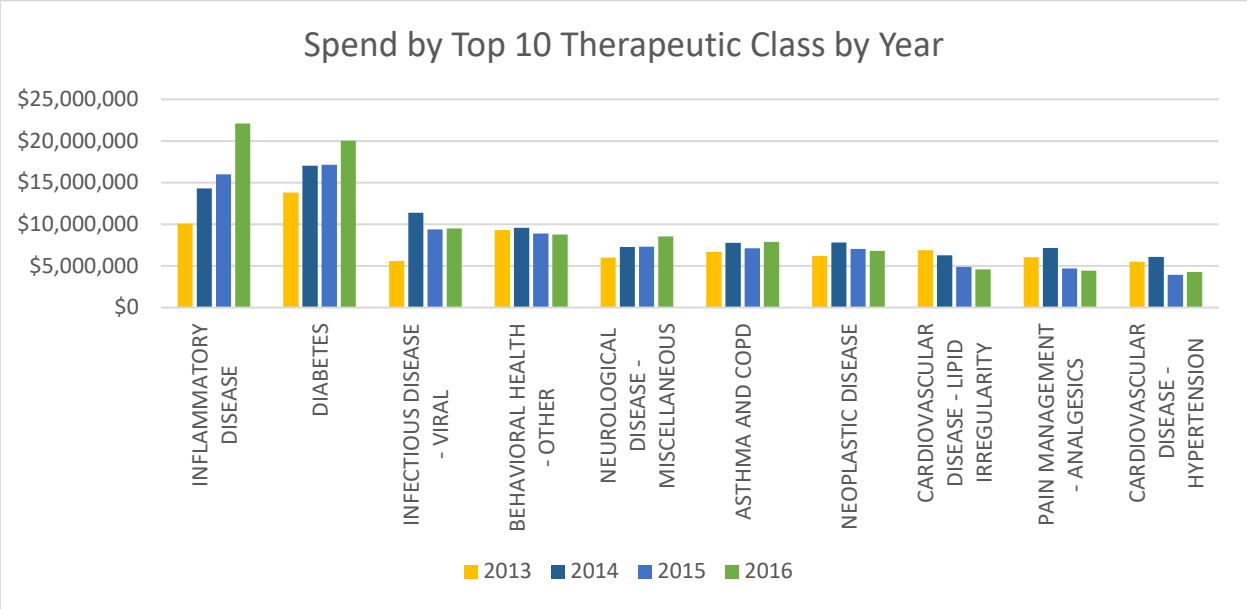


Figure 20: Spend by Top 10 Therapeutic Class by Year

Prescription Use by Type of Drug

The graph below shows spend for top ten drug by year. In almost all of the top ten drugs, expenses have increased which is driving the overall increase in pharmaceutical spend. The top ten drugs make up approximately 15.4% ($28M) of the total $181.8M drug spend in PY 2016 which is slightly up from the prior year of 14.8%. The top two drugs in 2016 are Humira Pen and Enbrel (both are drugs used to treat inflammation). The top three drugs make up more than half ($14.7M) of the spend for the top ten drugs ($28M).

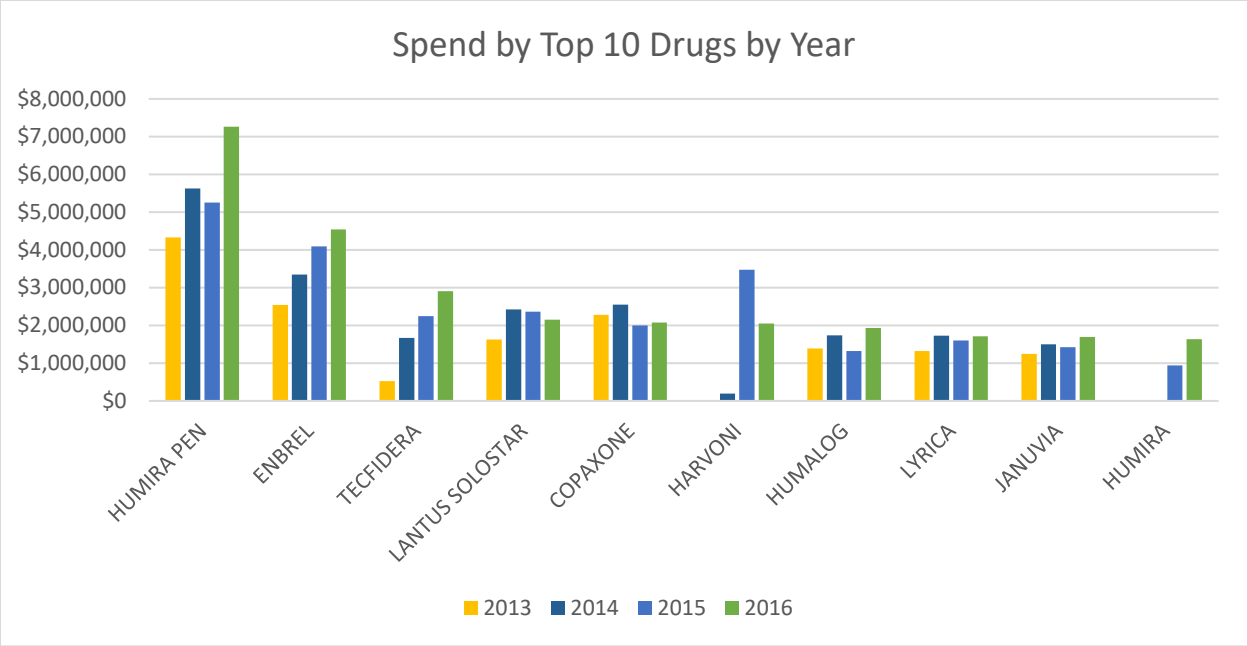


Figure 21: Spend by Top 10 Drugs by Year

Dental Plan Enrollment

Benefits Services Division offers two different types of dental plans: a fully-insured Dental Health Maintenance Organization (DHMO) plan administered by Total Dental Administrators and a self-insured Dental Preferred Provider Organization (DPPO) plan administered by Delta Dental.

DHMO Plan

Within the DHMO plan, services must be obtained from a participating dental provider (PDP). There is no annual deductible or out of pocket maximum. The plan coverage maximums include a $200 maximum reimbursement for non-PDP emergency services, $50 for emergency services less member cost share for the service and a $1,500 per person lifetime maximum for orthodontia. This plan is administered by Total Dental Administrators.

DPPO Plan

Within the DPPO plan, services may be obtained from any dentist and deductibles and out of pocket maximum apply. Benefits may be based on reasonable and customary charges. The plan coverage maximums include a $2,000 maximum per person per year and a $1,500 per person lifetime maximum for orthodontia. This plan is administered by Delta Dental.

The figure below shows how enrollment was distributed by plan and network between active, retired, university, and COBRA members. The subscriber references the employee and the member references the employee plus dependents.

Average Monthly Dental Enrollment by Plan					
		2016		2015	
Network	Plan Type	Subscribers	Members	Subscribers	Members
Active	DPPO	22,220	52,403	22,478	52,508
Retiree	DPPO	14,183	22,457	13,267	20,910
University	DPPO	16,646	33,292	14,967	31,226
COBRA	DPPO	206	296	174	243
Total Delta Dental		**53,255**	**108,448**	**50,885**	**104,887**
Active	DHMO	9,820	23,169	10,095	24,061
Retiree	DHMO	2,388	3,661	2,258	3,437
University	DHMO	6,060	12,717	5,979	12,578
COBRA	DHMO	71	104	73	102
Total Dental Administrators		**18,339**	**39,652**	**18,405**	**40,178**
Total		**71,594**	**148,099**	**69,290**	**145,065**

Figure 22: Average Dental Enrollment by Plan

Dental Premiums

The below tables show the dental premiums by plan and coverage tier per pay period for Active employees and Retirees.

Active Dental Premiums per Pay Period (26 pay periods)*				
Plan	Tier	Employee Premium	State Premium	Total Premium
DPPO	Employee only	$14.30	$2.29	$16.59
	Employee + adult	$30.33	$4.58	$34.91
	Employee + child	$23.34	$4.58	$27.92
	Family	$48.26	$6.32	$54.58
DHMO	Employee only	$1.86	$2.29	$4.15
	Employee + adult	$3.72	$4.58	$8.30
	Employee + child	$3.50	$4.58	$8.08
	Family	$6.12	$6.32	$12.44

*University of Arizona has 24 pay period deductions

Figure 23: Active Dental Premiums

Retiree Monthly Dental Premiums		
Plan	**Tier**	**Premium**
DPPO	Employee only	$35.94
	Employee + adult	$75.63
	Employee + child	$60.48
	Family	$118.26
DHMO	Employee only	$8.99
	Employee + adult	$17.99
	Employee + child	$17.51
	Family	$26.97

Figure 24: Retiree Dental Premiums

Dental Premium vs. Plan Cost

The PY 2016 contribution strategy for the self-insured dental plan resulted in employees paying 87% of the average monthly premium while the state paid the remaining 13%. The figure below shows how the average monthly premium compared to the average monthly plan cost for Active employees and Retirees and their dependents (Active and Retiree members).

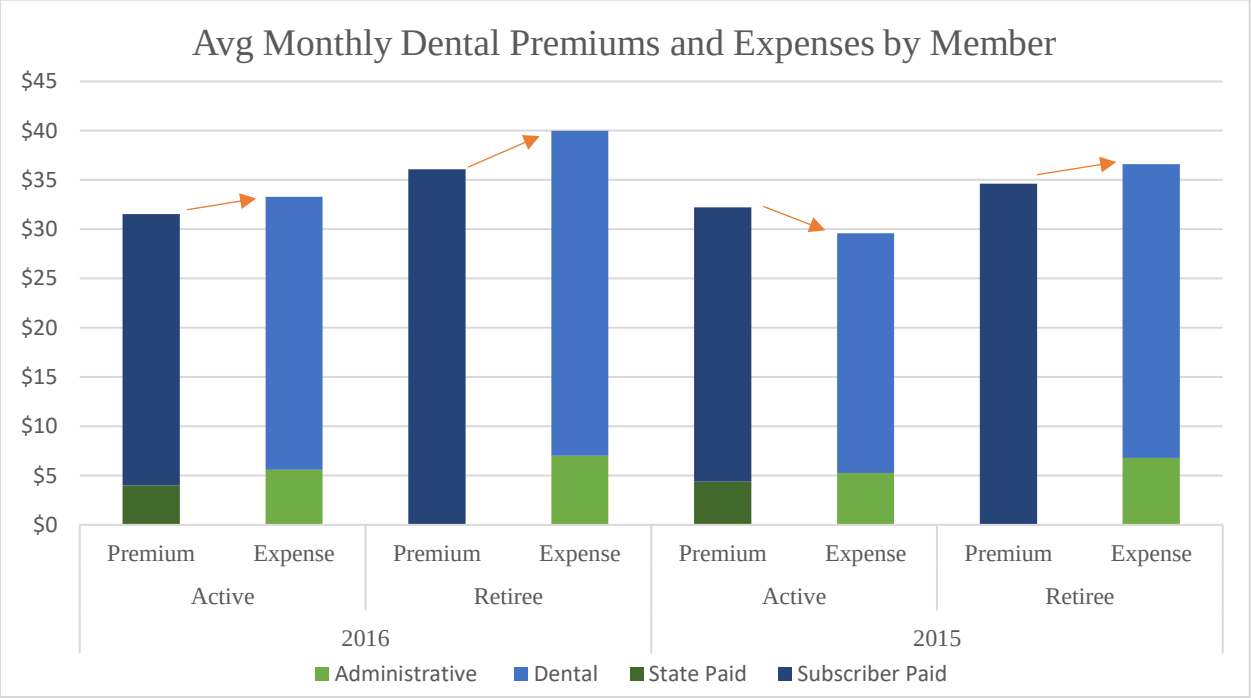


Figure 25: Average Dental Premiums and Expenses per Member

Expenses for Self-Insured Dental Plan

The figure below show the distribution of claims and expenses incurred in PY 2016 and the average annual cost to insure each type of subscriber/member.

2016 Self-Insured Dental Expenses by Active, Retiree			
Expenses	**Overall**	**Active**	**Retiree**
Dental Claims	$35,379,067	$26,349,427	$9,029,641
Rebates & Recoveries	$0	$0	$0
Administration Fees	$1,729,552	$1,254,336	$475,215
Appropriated Expenses	$231,641	$167,994	$63,646
Total Expenses	$37,340,259	$27,771,757	$9,568,502
IBNR Liability	$5,658,000	$4,213,934	$1,444,066
Total	$42,998,259	$31,985,691	$11,012,568
Enrollment in self-funded plans			
Subscribers	51,718	37,508	14,210
Members	107,573	85,121	22,452
Annual cost			
Per subscriber	$831	$853	$775
Per member	$400	$376	$490

Figure 26: Self-Insured Dental Expenses by Active and Retiree

Wellness

Benefits Services Division provides wellness programs and services to Active State employees. Members have access to preventive health screenings, health management and health education courses, annual flu vaccines, online lifestyle management programs, onsite seminars, and Employee Assistance Program (EAP) benefits.

The Health Impact Program (HIP) offers an incentive based employee wellness program for benefits eligible State of Arizona employees, and was first launched October 1, 2014 through September 30, 2015. In 2016, the program began in January and ran through October 31, 2016. The mission of HIP is to promote prevention as the first line of defense against chronic disease and encourage employees to participate in disease management so they can manage pre-existing conditions and enjoy greater total health and well-being.

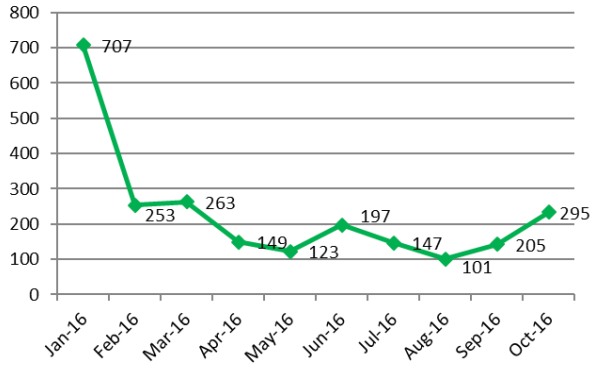
Employees who successfully completed the program by engaging in a variety of wellness activities while accumulating and logging progress towards an end goal of 500 points, were eligible to receive up to a $200 incentive payout at the of the year.

Engagement

The PY 2016 data graph below shows that of the 60,000 eligible members, there were 2,440 new employees in addition to the 7,955 employees registered in 2015, totaling 10,395 registered or

17% of the eligible population. 4,091 employees of those registered, completed the online Healthy Assessment which translates to a 39% completion rate.

PY 2016 Healthy Living Registrations



PY 2016 Health Assessment Completions

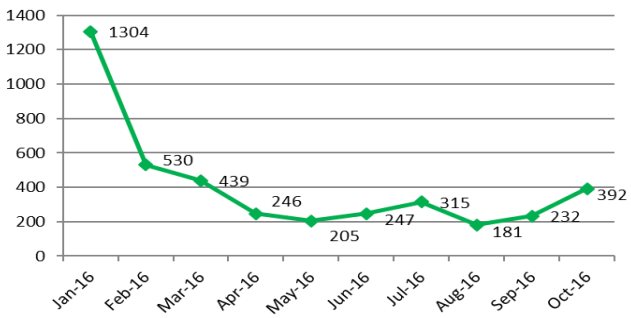


Figure 27: Healthy Living Registrations and Completions

Screening Utilization

The chart below shows the total utilization of health screening benefits during the PY 2016 and the number of at-risk employees referred to follow-up care.

PY 2016 Health Screenings			
	Events	**Participant**	**Referrals**
Mini Health Screening*	89	3,417	
Osteoporosis Screening		1,490	361
Prostate Specific Antigen (PSA)**		500	18
Hemoglobin A1C **		884	83
Mobile Onsite Mammography	70	1,091	27
Prostate Onsite Projects	30	489	28
Total	189	7,871	517

* The basic Mini Health Screening includes: full lipid panel, fasting blood glucose, blood pressure, BMI, and body composition.

** New tests offered as a package with the basic Mini Health Screening.

Figure 28: Health Screenings

The table below shows the total utilization for the PY 2016 State Wellness Annual Flu Vaccine Program held September 1 through December 31, 2016. A total of 14,842 vaccines were given to benefits Active members, Retirees and their dependents. Members had access to the flu vaccine at 405 locations throughout the state. 94% of members who received a flu vaccine did so at a worksite or open enrollment clinic. To contrast, a total of 20,142 members and their dependents received flu vaccines through the medical plan in PY 2016.

PY 2016 Flu Vaccines		
	Locations	**Participants**
State Agency Worksite	198	7,729
University Worksite	35	4,700
Combined Worksite (Wesley Bolin)	3	821
Open Enrollment Clinics	10	709
Public Clinics	159	883
Total	405	14,842

Figure 29: Flu Vaccines

CDC estimates flu shot savings of between $15 and $84 per vaccinated person, or $2.58 per dollar spent on vaccination; a possible $4,000 savings for every averted illness. Approximate maximum ROI of 3:1.

Incentives

The graph below shows the distribution of points of program participants comparing PY 2016 to PY 2015. 4,327 (42%) of registered participants logged points; 2,039 of the 2,053 logging 500 points earned the incentive for an estimated payout of $407k (20% of total registered). This represents a 13.50% increase in those earning the reward from PY 2015. A 3.85% of total eligible employees earned incentive.

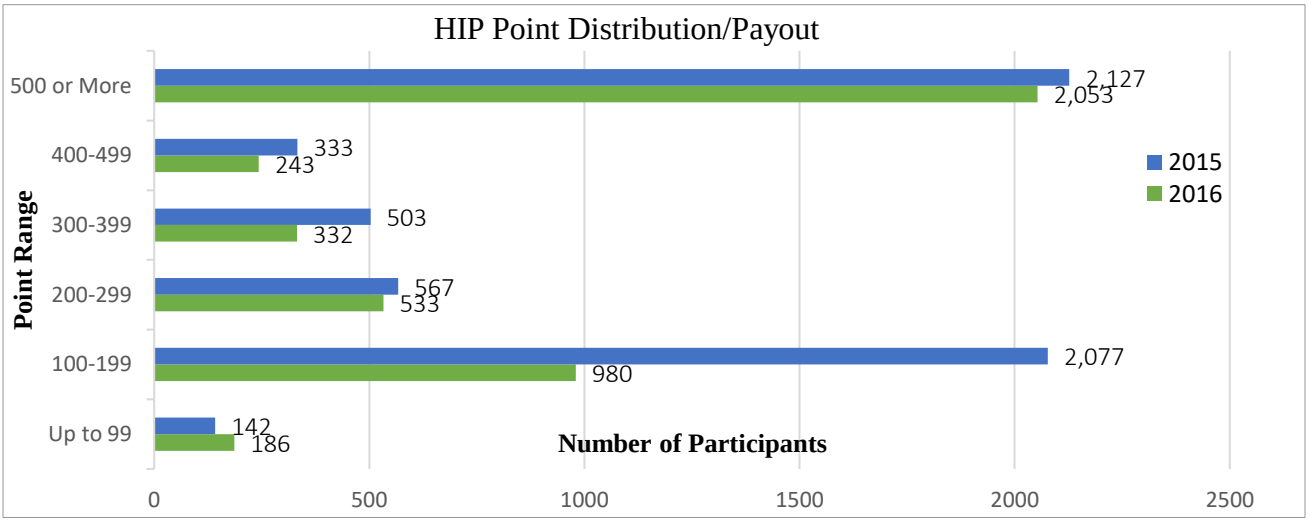


Figure 30: Distribution of Points

By providing the Health Impact Program (HIP) Framework and incentive component, the year over year participation metrics showed an increase in employee engagement in preventive services, screening referrals, and educational/behavior change activities.

Employee Assistance Program

The table below shows the utilization for the Employee Assistance Program (EAP) and support services offered to agencies covered under the Benefits Services Division. Total utilization for PY

2016 reached 31%, an increase from 29% in PY 2015, showing sustained high usage especially when compared to the 18.6% national standard for government entities. Benefit Services Division covered agencies continue to show utilization higher than our EAP vendor's Book of Business.

The Department of Education was added to the Benefit Services Division program effective January 1st, 2016.

PY 2016 EAP Utilization			
	Eligible Population	**Users**	**Utilization Rate**
Live Telephonic Access		2,737	7.2%
EAP		2,172	5.8%
FamilySource		126	0.3%
FinancialConnect		88	0.2%
LegalConnect		351	0.9%
Online Access		8,042	21.3%
EAP		1,639	4.3%
FamilySource		1,855	4.9%
FinancialConnect		742	2.0%
GlobalConnect		0	0.0%
Health & Wellness		1,633	4.3%
LegalConnect		2,004	5.3%
Critical Incident Stress Debriefing		379	1.0%
Trainings		544	1.4%
Overall Utilization	37,705	11,702	31.0%

Figure 31: EAP Utilization

In addition to health screenings, vaccines, and EAP services, the strategic plan for PY 2016 continued to provide employees with increased access to online mindfulness and stress reduction by enhancing the options for participation in the sessions through eMindful, Inc.

PY 2016 Online Courses		
	Classes	**Participants**
Mindfulness at Work 1-hr webinars	24	3,261

Figure 32: Online Course Participation

Life, Disability, Vision Insurance and Flexible Spending Accounts

Fund 3035, ERE/Benefits Administration, is used to pay Fully Insured premiums and administer State employees benefit plans other than health and dental. These include basis, supplemental, and dependent life insurance, short-term and non-ASRS long term disability insurance, vision insurance, and medical and dependent care flexible spending accounts. Basic life and non-ASRS long term disability insurance is funded solely by State agency premiums (employer premiums) while all others are funded solely be employee premiums. Fund 3035 is primarily a pass-through fund with collections funding the premiums payments. The table above is a cash statement of receipts received and expenses paid during PY 2016 that related to PY 2016 incurred revenues and expenditures as well as prior.

ERE/Benefits Administration Fund Summary				
				Plan Year 2016
Beginning Fund Balance January 01, 2016				**$3,967,635**
Revenues				
Insurance Product	**Amount**			
Basic Life	$1,128,853			
Supplemental Life	10,366,183			
Dependent Life	2,733,133			
Short Term Disability	7,052,965			
Long Term Disability	3,418,727			
Total Life & Disability			**$24,699,861**	
Vision			**5,261,996**	
Health Care FSA	$3,365,647			
Dependent Care FSA	1,282,072			
Total Flex Spending			**$4,647,719**	
Total Revenues				**$34,609,576**
Expenditures				
Insurance Product	**Amount**	**Penalties**		
Basic Life	1,127,417	(13,497)		
Supplemental Life	10,308,070	(128,912)		
Dependent Life	2,786,573	(35,685)		
Short Term Disability	7,055,783	(110,037)		
Long Term Disability	3,412,014	(35,665)		
Total Life & Disability*			**$24,366,060**	
Vision*	5,248,314	(77,658)	**$5,170,656**	
Health Care FSA	3,392,166			
Dependent Care FSA	1,255,299			
Administrative Fees*	106,611			
Total Flex Spending			**$4,754,075**	
Total Expenditures	**$34,692,246**	**(401,455)**		**$34,290,791**
Ending Fund Balance December 31, 2016				**$4,286,420**

*Vendor administrative fees and fully insured premiums are paid 55 days in arrears per contract.

Figure 33: ERE/Benefits Administration Fund 3035 Summary

Vendor Performance Standards

Pursuant to A.R.S. § 38-658(B), "On or before October 1 of each year, the Director of the Department of Administration shall report to the Joint Legislative Budget Committee on the performance standards for health plans, including indemnity health insurance, hospital and medical service plans, dental plans, and health maintenance organizations."

Among the terms of the self-insured health insurance contracts and other contracts the Benefit Services Division administers are several ADOA-negotiated performance measures with specific financial guarantees tied to vendor performance of the contracted services. If a vendor fails to meet any of the measures within the specified performance range, the vendor is required to submit a Corrective Action Plan detailing why the measure was missed and any actions taken to address the issue and improve performance to meet the standard of the measure. A percentage of the vendor's annual payment, or previously agreed upon amount, is then withheld by ADOA as a performance penalty per the terms of the vendor contract. This percentage is allocated among the more critical measures of the contract.

The following is a report of the agreed-upon performance standards both met and missed by contracted vendors during PY 2016. In each case, performance penalties for measures missed are assessed per the terms of the individual vendor contract. As some performance metrics are yet to be finalized, the estimated performance penalty paid to Benefit Services Division related to PY 2016 will be approximately $360,000.

Aetna

Performance Measures	
Performance Measure	**Fees At Risk**
Total Performance Measures = 190 Targets successfully met = 178 Targets missed resulting in penalties = 8 Targets Pending = 4	Approximately $13,901

Performance Measures Not Met		
Performance Measure	**Fees At Risk**	**Total % Assessed**
Customer Service – Phone Line: Call abandonment rate is ≤ 3%; average speed to answer for all phone calls is 30 seconds or less	1.00% of Total Administrative Fee	Missed 1 of 12 months measured = 0.08%
Appeals – At least 95% of urgent pre-service appeals are resolved within 15 calendar days of receipt; post-service appeals resolved within 30 days.	1.50% of Total Administrative Fee	Missed 2 of 12 months measured = 0.25%
Claims – Processing Turnaround Time: At least 98% of all fully-documented claims will	1.00% of Total Administrative Fee	Missed 1 of 12 months measured = 0.08%

Performance Measures Not Met		
Performance Measure	**Fees At Risk**	**Total % Assessed**
be processed within 30 calendar days of receipt		
HSA Administration – Quality Member Phone Services: Call abandonment rate is ≤ 3%; average speed to answer for all phone calls is 30 seconds or less	3.00% of HSA Fees	Missed 3 of 12 months measured = 0.75%
Case Management and Disease Management Customer Service – Quality nurse line phone services: Call abandonment rate is ≤ 3%; average speed to answer for all phone calls will 30 seconds or less; and 90% of all calls must be appropriately triaged	1.00% of Total Administrative Fee	Missed annual measurement = 1.00%
Case Management – Post Discharge Outreach: 95% of identified post discharge cases receive an outreach call within 7 business days of discharge	.50% of Total Administrative Fee	Missed annual measurement = .50%

Cigna

Performance Measures	
Performance Measure	**Fees At Risk**
Total Performance Measures = 198 Targets successfully met = 176 Targets missed resulting in penalties = 15 Targets Pending = 7	Approximately $10,132

Performance Measures Not Met		
Performance Measure	**Fees At Risk**	**Total % Assessed**
Appeals - Accurate and timely response to member request for review; urgent appeals resolved within three (3) business days of request, pre-service resolved within 15 calendar days of request and post-service resolved within 30 calendar days of request	0.75% of Total Administrative Fee	Missed 9 of 12 months measured = 0.56%
Customer Service Nurse Line - Cigna will provide Nurse Line phone service to members with no more than 3% abandonment rate, an average speed to answer of 30 seconds or less, and 90% of all calls must be appropriately triaged	0.66% of Total Administrative Fee	Missed 4 of 12 months measured = 0.22%
Claims – Processing Accuracy: At least 99% of claims will be processed accurately	1.34% of Total Administrative Fee	Missed 2 of 12 months measured = 0.22%

UnitedHealthcare

Performance Measures	
Performance Measure	**Fees At Risk**
Total Performance Measures = 198 Targets successfully met = 184 Targets missed resulting in penalties = 6 Targets Pending = 8	Approximately $36,007

Performance Measures Not Met		
Performance Measure	**Fees At Risk**	**Total % Assessed**
Customer Service - UHC will provide phone service to members with no more than 3% abandonment rates and average speed to answer of 30 seconds or less	1.00% of Total Administrative Fee	Missed 2 of 12 months measured = 0.16%
Case Management and Disease Management - Phone Line: Call abandonment rate is ≤ 3%; average speed to answer for all phone calls will 30 seconds or less	0.50% of Total Administrative Fee	Missed 2 of 12 months measured = 0.08%

Blue Cross Blue Shield (BCBS) of Arizona

Performance Measures	
Performance Measure	**Fees At Risk**
Total Performance Measures = 198 Targets successfully met = 171 Targets missed resulting in penalties = 19 Targets Pending = 8	Approximately $56,863

Performance Measures Not Met		
Performance Measure	**Fees At Risk**	**Total % Assessed**
Claims - At least 99% of all fully documented claims will be processed within 30 calendar days of receipt	2.00% of Total Administrative Fee	Missed 2 of 12 months measured = 0.33%
Claims – At least 98% of claims dollars submitted for payment will be accurately processed and paid		Missed 1 of 12 months measured = 0.16%=016%
Claims – At least 99% of all claims will be processed accurately	1.00% of Total Administrative Fee	Missed 9 of 12 measured = 0.75%
Appeals - Accurate and timely response to member request for review; urgent appeals resolved within three (3) business days of request, pre-service resolved within 15	0.75% of Total Administrative Fee	Missed 1 of 12 measured = 0.06%

Performance Measures Not Met		
Performance Measure	**Fees At Risk**	**Total % Assessed**
calendar days of request and post-service resolved within 30 calendar days of request		
Reporting Timeliness – Agreed upon reporting packages must be submitted within stated timeframes	0.50% of Total Administrative Fee	Missed 2 of 12 months measured = 0.08%
Case Management/Disease Management Customer Service - BCBS will provide Nurse Line (demand management) phone service to members with no more than 3% abandonment rate, an average speed to answer of 30 seconds or less	1.00% of Total Administrative Fee	Missed 2 of 12 months measured = 0.16%
Disease Management - At least 50% of members identified and screened must participate	0.50% of Total Administrative Fee	Missed 2 of 4 quarters measured = 0.25%

MedImpact

Performance Measures	
Performance Measure	**Fees At Risk**
Total Performance Measures = 113 Targets successfully met = 111	Approximately $25,000

Performance Measures Not Met		
Performance Measure	**Fees At Risk**	**Total % Assessed**
Reporting Timeliness – Agreed upon reporting packages must be submitted within stated timeframes	$50,000 annually	Missed 2 of 4 quarters measured = 50%

Delta Dental

Performance Measures	
Performance Measure	**Fees At Risk**
Total Performance Measures = 262 Targets successfully met = 261 Targets Pending = 1	No penalties

Performance Measures Not Met		
Performance Measure	**Fees At Risk**	**Total % Assessed**
No targets missed		

Total Dental Administrators

Performance Measures	
Performance Measure	**Fees At Risk**
Total Performance Measures = 136 Targets successfully met = 135 Targets missed resulting in penalties = 0 Targets Pending = 1	No penalties

Performance Measures Not Met		
Performance Measure	**Fees At Risk**	**Total % Assessed**
No Targets Missed		

Compsych

Performance Measures	
Performance Measure	**Fees At Risk**
Total Performance Measures = 38 Targets successfully met = 38 Targets missed resulting in penalties = 0	No penalties

Performance Measures Not Met		
Performance Measure	**Fees At Risk**	**Total % Assessed**
Less than 3% of calls abandoned. This is a Customer Service metric for the Guidance Resources Unit only.	3.00% of Total Administrative Fee	Missed 2 of 4 quarters measured = 1.50%

Avesis

Performance Measures	
Performance Measure	**Fees At Risk**
Total Performance Measures = 182 Targets successfully met = 181 Targets missed resulting in penalties = 0 Targets Pending = 1	No penalties

Performance Measures Not Met		
Performance Measure	**Fees At Risk**	**Total % Assessed**
N/A	N/A	N/A

Application Software, Inc. ("ASI")

Performance Measures	
Performance Measure	**Fees At Risk**
Total Performance Measures = 49 Targets successfully met = 42 Targets missed resulting in penalties = 7	Approximately $3,793.42

Performance Measures Not Met		
Performance Measure	**Fees At Risk**	**Total % Assessed**
Account Management/Customer Service - At least 80% of calls will be answered within 30 seconds or less.	2.00% of Total Administrative Fees	Missed 3 of 4 quarters measured = 1.50%
Account Management/Customer Service - No more than 3% of calls abandoned.	2.00% of Total Administrative Fees	Missed 3 of 4 quarters measured = 1.50%
Program/Claim Administration -All fully documented claims received will be processed within 2 business days.	2.50% of Total Administrative Fees	Missed 1 of 4 quarters measured = .625%

The Hartford

Performance Measures	
Performance Measure	**Fees At Risk**
Total Performance Measures = 136 Targets successfully met = 135 Targets missed resulting in penalties = 0 Targets pending = 1	No penalties

Performance Measures Not Met		
Performance Measure	**Fees At Risk**	**Total % Assessed**
No targets missed		

Audit Services

The Benefit Services Division-Audit Services Unit provides assurances that add value and improve the operations of Benefit Services. Audit Services performs systematic evaluations of contract compliance, operational controls, risk management, and the implementation of best practices to support BSD objectives.

During PY 2016, four audit projects were completed to ensure the health plan vendors appropriately provided contracted services. The audit schedule for the plan year was developed using a combination of contract elements and risk analysis. An overview of the completed project results for the 2016 plan year is shown below including recommendations made, implemented recommendations*, identified savings, and health plan recovery dollars.

Recommendations	Implemented Recommendations *	Identified Savings	Recovery Dollars	Pending Recovery
3	1	$9,719.23	$0	$0

Figure 34: Audit Recommendation Summary

* Implementation of recommendations may vary based on the completion of all corrective action plan directives. In many cases, directives may still be in progress and may roll over to the new plan year.

Individual audit objectives were developed with the consideration of dollar value, complexity of operations, changes in personnel or operations, loss exposure, and previous audit results. Audits were completed, but were not limited to the following functional areas:

Functional Area	Audit Methodology
Vendor operating transactions	Statement on Standards for Attestation Engagements No. 16 Audits (SSAE 16)
ADOA accuracy of shared data	Dependent Eligibility Audits (DEA)
Audit program improvement initiatives	Administrative functions and program-specific improvements

Figure 35: Audit Functional Area and Methodology

Vendor Operating Transactions

All health plan contracted vendors that pay claims are required to provide a copy of a SSAE 16, which is an independently assessed operational annual or semi-annual audit. SSAE 16 audits evaluate the internal controls of the vendor's systems utilized to process claims and identify deficiencies. Audit services reviewed the SSAE 16 reports provided by each of the vendor's external auditors. There were no instances of significant operating failure noted and no corrective action was required. In addition, audits performed by external or third party vendors are evaluated and considered for the development of the audit schedule when there is significant impact the on the health plan and contract compliance (i.e. large medical and/or pharmacy claims audit).

ADOA Accuracy of Shared Data

Dependent Eligibility audits are performed annually on the health plan's membership. The eligibility audits provide assurance that dependent eligibility is monitored effectively and the risk of claims paid on behalf of ineligible dependents is minimized. The results of the eligibility audit indicated that two ineligible dependents were enrolled in the plan. One dependent erroneously received total benefits of $2,301.95 due to an unreported qualified life event. Appropriate documentation was not received for one dependent, however, no erroneous payments of benefits were made on the dependent's behalf. Additionally, during the Plan Year, documentation was reviewed for a member and dependent who were not included in the annual Dependent Eligibility Audit. Suspicion of inappropriate conduct by the member was based on contact from the member's agency or peers. It was determined that one dependent was not married to the member at the time of enrollment. A total of $5,654.50 in benefits was paid in error on behalf of the dependent. Eligibility documentation and review results for members not selected for the audit, are included as Additional Information in the findings of Dependent Eligibility Audit.

Audit Program Improvement Initiatives

In addition to the regularly scheduled audits, reviews, and evaluations listed above, Audit Services assisted in performing a review of HITF members with premiums in a collections status. Claims paid during the non-payment of premium period on behalf of these members were identified and used to assist in determining the remediation of the unpaid premiums.

Audit Services continues to strive towards improvement and efficiency; the focus during the PY 2016 was to streamline administrative functions to improve audit program initiatives.

Appendix

Special Employee Health Fund Cash Statement				
				Plan Year 2016
Beginning Fund Balance January 01, 2016^				**$369,000,031**
Revenues				
Source	**Premiums**			
ADOA Health Plan (EE)	$129,470,673			
ADOA Health Plan (ER)	586,525,582			
BCBS NAU Plan (EE)	8,391,168			
BCBS NAU Plan (ER)	33,527,955			
ADOA Dental Plan (EE)	29,014,701			
ADOA Dental Plan (ER)	13,123,597			
PrePaid Dental Plan (EE)	1,578,360			
PrePaid Dental Plan (ER)	2,093,511			
Other Revenue	239,160			
Net Revenue	**$803,964,707**			**$803,964,707**
Expenditures				
Vendor	**Admin Fees**	**Penalties**		
Aetna	2,912,532	(139,209)		
AHH Medical Management	60	-		
AmeriBen	3,610	-		
Blue Cross Blue Sheild AZ	5,909,318	(115,065)		
Cigna	2,361,877	(16,905)		
UnitedHealthcare	13,700,011	(38,501)		
MedImpact	1,651,309	-		
HSA Funding (EE and ER)	982,888	-		
Delta Dental	1,729,552	-		
HIP Payout	430,357	-		
ACA Related Taxes/Fees	4,906,327	-		
AG Collection Fees	1,965	-		
Net Administrative Fees***	$34,589,807	($309,681)	$34,280,126	
	Claims	**Recoveries***		
Aetna	$39,805,443	-		
AmeriBen	6,592	(266,587)		
Blue Cross Blue Shield AZ	132,313,036	(169,059)		
Cigna	57,105,475	-		
UnitedHealthcare	363,326,031	(150,453)		
Other Medical**	-	(959)		
MedImpact	191,685,214	(10,158,063)		
Medicare Part D Retiree Drug Subsidy	-	(11,481,947)		
Delta Dental	37,154,528	-		
Other Wellness	638,441	-		
Net Claims	$822,034,760	($22,227,068)	$799,807,692	
Self-Insured Expenditures	**$856,624,566**	**($22,536,749)**	**$834,087,818**	
	Premiums	**Penalties**		
BCBS (NAU Only)	$40,427,829	-		
Total Dental Administrators	3,674,549	($75,302)		
Fully Insured Expenditures***	**$44,102,378**	**($75,302)**	**$44,027,076**	
HITF Operating	$4,968,834	-		
Fund Transfers Out^^	4,076,000	-		
Federal Participation Reimbursement	6,158,416	-		
Administrative/Cash Adjustments	30,306	-		
Operating Expenes and Transfers	**$15,233,556**	**$0**	**$15,233,556**	
Net Expenditures and Transfers	**$915,960,500**	**($22,612,051)**		**$893,348,449**
Ending Fund Balance December 31, 2016				**$279,616,289**
IBNR Liability (Medical & Dental)				$98,663,139
Contingency Reserve (Medical & Dental)				$98,663,139
Unrestricted Cash Balance As Of December 31, 2016				**$82,290,011**

* Recoveries include Medicare Part D Retiree Drug Subsidy reimbursement, prescription drug rebates, overpayment recoveries (including stop payments and voids), subrogation recoveries, workers compensation recoveries from Risk Management, etc.

** Other Medical includes recoveries from Risk Management for Worker Comp claims and UMR.

*** Vendor administrative fees and fully insured premiums are paid 55 days in arrears per contract.

^ The ending balance from PY 2015 report equals to the beginning balance for PY 2016. PY 2015 ending balance was overstated by $53,565.

^^ Fund transfers from HITF to other State funds.

Figure 36: Special Employee Health Fund Cash Statement

Glossary of Terms

Active member(s) – An employee and their eligible dependents, as defined in the Arizona Administrative Code, who are enrolled in one of the health plan options offered by the State. (Also referred to as "actives".)

Administrative fees – Fees paid to third-party vendors for plan administration, network rental, transplant network access fees, shared savings for negotiated discounted rates with other providers, COBRA administration, direct pay billing, additional reporting billing, State fees (MA, MI and NY), and bank reconciliation fees.

Case management – A collaborative process that facilitates recommended treatment plans to ensure that appropriate medical care is provided to disabled, ill, or injured individuals.

Claim – A provider's demand upon the payer for payment for medical services or products.

Claim appeal – A request by an insured member for a review of the denial of coverage for a specific medical procedure contemplated or performed.

COBRA, Consolidated Omnibus Budget Reconciliation Act of 1985 – A federal law that requires an employer to allow eligible employees, retirees, and their dependents to continue their health coverage after they have terminated their employment or are no longer eligible for the health plan - COBRA enrollees must pay the total premium, in addition to an administrative fee of 2%.

Contribution strategy – A premium structure that includes both the employer's financial contribution and the employee's financial contribution towards the total plan cost.

Copayment – A form of medical cost-sharing in the health plan that requires the member to pay a fixed dollar amount for a medical service or prescription.

Deductible – A fixed dollar amount that a member pays during the plan year, before the health plan starts to make payments for covered medical services.

Dependent – An unmarried child or a spouse of the employee who meets the conditions established by the relevant plan description.

DHMO/Pre-Paid Dental – A dental plan that offers members dental services with no annual maximums or claim forms, and services based on a discounted rate. Total Dental is the current prepaid dental vendor.

DPPO – A dental plan, with an in-network and out-of-network coinsurance structure, that allows members to visit any dentist. There is an annual deductible, and maximum annual benefit of $2,000 per member per year for dental services. The current administrator for the DPPO plan is Delta Dental.

Disease management – A comprehensive, ongoing, and coordinated approach to achieving desired outcomes for a population of patients. These outcomes include improving members' clinical conditions and qualities of life as well as reducing unnecessary healthcare costs. These objectives require rigorous, protocol-based, clinical management in conjunction with intensive patient education, coaching, and monitoring.

Eligibility appeal – The process for a member to request a review of a health plan decision regarding a claimant's qualifications for, or entitlement to, benefits under a plan.

Employee – As defined in the Arizona Administrative Code who works for the State of Arizona or a State university.

Employee Group Waiver Program (EGWP) – An employer group Medicare Prescription D drug plan.

Exclusive Provider Organization (EPO) – A health plan designed with an exclusive provider organization or network. Enrollees are limited to access in-network providers and are subject to co-pays. Any exceptions require prior authorization.

Flexible spending account (FSA) – An account that can be set up through the State's Benefit Options program, an FSA allows an employee to set aside a portion of his/her earnings to pay for qualified medical and dependent care expenses. Money deducted from an employee's pay and put into an FSA is not subject to payroll taxes.

Formulary – A list of preferred medications covered by the health plan. The list contains generic and brand-name drugs. The most cost-effective brand-name drugs are placed in the "preferred" category and all other brand-name drugs are placed in the "non-preferred" category.

Fully-insured – An insurance model wherein a commercial insurer collects premiums, pays claims for services, and takes the risk of revenue to expense. Benefit Options may collect the premiums for transfer to the commercial insurer.

High Deductible Health Plan (HDHP) – A health plan designed with an open access provider organization or network. Enrollees have access to in-network and out-of-network providers, and are subject to co-insurance and higher annual deductibles than traditional plans. Out-of-network providers require greater co-insurance.

Health Savings Account (HSA) – An account that allows individuals to pay for current health expenses and save for future health expenses on a tax-free basis. Only high deductive health plans are HSA-eligible.

Integrated – A health plan operation administered by one entity. Such operations include: claims processing and payment, a network of medical providers, utilization management, case management, and disease management services.

Medicare – The federal health insurance program provided to those who are age 65 and older, or those with disabilities, who are eligible for Social Security benefits. Medicare has four parts: Part A, which covers hospitalization; Part B, which covers physicians and medical providers; Part C, which expands the availability of managed care arrangements for Medicare recipients; and Part D, which provides a prescription drug benefit. Retirees signing up for ADOA insurance must enroll in Parts A and B, but not C or D.

Member – A health plan participant. This individual can be an employee, retiree, spouse, or dependent.

Network – An organization that contracts with providers (hospitals, physicians, and other health care professionals) to provide health care services to members. Contract terms include agreed upon fee arrangements for services and performance standards.

Non-integrated – A health plan with operations administered by multiple entities. These operations include claims processing and payments, a network of medical providers, and disease management services.

Payer – The entity responsible for paying a claim.

Pharmacy Benefit Manager (PBM) – An organization that provides a pharmacy network, processes and pays for all pharmacy claims, and negotiates discounts on medicines directly from the pharmaceutical manufacturers. These discounts are passed to the employer/payer in the form of rebates and reduced costs in the formulary.

Plan Year (PY) – Defined as the period of January 1 through December 31 of a given year.

Preferred Provider Organization (PPO) – A health plan designed with a preferred provider organization or network. Enrollees have access to in-network and out-of-network providers, and are subject to co-pays, or co-insurance, and annual deductibles. Out-of-network providers require greater co-pays.

Premium – The agreed-upon fees paid for medical insurance coverage. Premiums are paid by both the employer and the health plan member.

Retiree – A former State of Arizona employee, State university employee, officer, or elected official who is retired under a State-sponsored retirement plan. For reporting purposes, this term encompasses both actual retirees and their dependents.

Self-funded – An insurance program wherein Benefit Options collects premiums, pays claims, and assumes the risk of revenues to expenses.

Self-insured – A plan that is funded by the employer who is financially responsible for all medical claims and administrative expenses.

Spouse – A dependent legally married to an employee or a retiree, as defined by the Arizona Revised Statutes.

Subscriber – An employee, officer, elected official, or retiree who is eligible and enrolls in the health plan.

Third party administrator – An organization that handles all administrative functions of a health plan including: processing and paying claims, compiling and producing management reports, and providing customer service.

Utilization management – The evaluation of appropriateness and efficiency of health care services procedures and facilities according to established criteria or guidelines and under the provisions of an applicable health benefits plan.

Utilization review – A process whereby an insurer evaluates the appropriateness, necessity, and cost of services provided.

Utilizer – A member who receives a specific service.